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Early career registered nurses: How and why do they stay? Exploring their disorienting dilemmas

Jane Alison Douglas

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Early career registered nurses:
How and why do they stay?
Exploring their disorienting dilemmas

Jane Alison Douglas

Supervisors:

Professor Lorna Moxham & Dr Sharon Bourgeois

This thesis is presented as part of the requirement for the
conferral of the degree:

Doctor of Philosophy

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School of Nursing

Abstract

This study explores the experiences of Early Career Registered Nurses (ECRN) and asks how and why they stay in nursing by exploring their disorienting dilemmas. ECRNs are those in their first five years of practice having completed a pre-registration program of study leading to registration as a Registered Nurse (RN). For this study, 13 ECRNs, who were working as RNs in Australia and had been registered for between one and five years (inclusive) were interviewed. Ethics approval was granted for the study through the University of Wollongong.

Shortages of RNs are being experienced globally, and are forecast to worsen with the World Health Organization (WHO) predicting that an additional nine million nurses and midwives will be needed by 2030. While complex, three main reasons are suggested for the current and predicted shortages. Firstly, the number of people attracted to nursing is low, secondly, decreasing numbers due to RN attrition from the workforce and thirdly, changes in demographic and economic situations that have resulted in increasing demand for nursing services (Australian Institute of Health and Welfare (AIHW), 2016; Buchan, Schaffer, & Catton, 2018; WHO, 2014).

The implications of RN shortages include threats to the health, safety and wellbeing of those accessing health care services (patients and clients) and those who provide healthcare, including the RNs who remain in the workforce. There is a need to identify, develop and implement strategies that attract people to the profession and retain them as RNs once in the workforce.

A plethora of research investigating the recruitment, attrition and retention of RNs generally exists; there is however a gap in the literature about the experiences of ECRNs. During this period ECRNs are at risk of leaving the profession, based on findings extrapolated from studies investigating the intent to leave (for example, Rudman, Gustavsson, & Hultell, 2014). The current study adds to the literature by investigating how ECRNs make sense of their experiences, face their disorienting dilemmas and make the decision to stay working in the profession. This study listens to and shares the voices and experiences of a group of ECRNs who have chosen to stay, learning from them what led to their decision and the implications for learning across future cohorts.

A qualitative methodology employing a staged, narrative approach was used, and transformative learning theory provided the philosophical and theoretical principles guiding the study. ECRNs participated in semi-structured, in-depth interviews that underwent iterative and deepening levels of analysis including the formation of stories to identify themes.

The findings in this study address the elements of the research question, looking firstly at the disorienting dilemmas and then how and why ECRNs stay. Challenges to the developing identity of ECRNs were the result of unexpected and difficult workplace relationships, unfounded expectations and when unexamined assumptions and frames of reference were brought into question resulting in disorienting dilemmas. For this group, it was relationships that led to disorienting dilemmas, but it was through relationships that they were able to begin to make sense of their experience. Intersubjective relationships provided safe spaces where critical reflection and dialogue

could occur, offering the possibility of emancipation from unfounded expectations; perspective transformations and; the movement toward authentic ways of being as nurses and people. By reflecting on experiences critically, through dialogue, the ECRNs in this study were able to move beyond unquestioned and unrealistic expectations thus learning the value of human connection and being with the other, as the RN role was becoming part of their ontology. The reasons why they stayed linked back to the reasons they decided to become nurses in the first place; the desire to enact an altruistic intent by discovering the value of human connection.

This research has implications for future directions of nurse education and curriculum development. The findings establish the centrality of relational learning and the importance of intersubjective relationships for ECRNs in developing and applying learning processes that are authentic and build strong and supportive bridges between university and workplace settings. The recommendations are drawn from these findings and point toward the future based on these implications.

Dedication



This thesis is dedicated to my father Ron, a good man, whose death from pancreatic cancer changed me in more ways than I could ever have imagined. Being with him throughout his illness allowed me to see how important nurses are and developed in me the desire to be the best nurse I could be.

Dad instilled in me a love of red wine and a sound work ethic that meant always attempting to do what is right, inspiring me to fight the good fight, by never losing sight of those with whom I live and work and valuing people above all else.

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Learning happens everywhere, anywhere and about everything and this tour de PhD has been no exception.

This thesis marks the end of my PhD journey, which has continued over a significant number of years, becoming a way of life. However, thankfully I have not walked this path alone, and there are many family members, guides, teachers, companions, friends and colleagues to acknowledge and thank.

To Brian my partner and best friend, thank you for being there as you are in all parts of my life. Thank you for the unwavering belief in my ability to see this journey through and for your ongoing care, help and encouragement. Thanks to my children James and Alison and their partners, Leah and Brad, who have kept me grounded and connected to the things that are truly important including the gift of family and three beautiful grandchildren, Matilda, Harry and Thomas. Thanks to my parents Ron and Dorothy who provided a solid grounding. To the girls, Daisy and Mia our two faithful golden retrievers who were and continue to be, active and uncomplaining listeners and companions.

To the ECRNs who participated in this study, thank you, for so generously sharing your time and gifting the stories of your experiences. Your openness and strength are admirable, and you will always hold a place in my heart.

To my co-supervisor Dr Sharon Bourgeois, thank you for your continued and ongoing support and care, for being beside me from start to finish, for offering sage advice, constant encouragement and wisdom. I will always be grateful for the chance to work with you and continue to admire your knowledge, gentle honesty and ability to think about things differently. I have learned so much from you along the way that will stay with me.

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I would like to express my sincere thanks to the Faculty of Science, Medicine, and Health and the School of Nursing at the University of Wollongong (UOW) for providing the opportunity and support to undertake a PhD. I would like to express my appreciation for

funding my attendance at the World Nursing Conference in Singapore in July 2018 where I was fortunate enough to present my research to an international audience.

Publications and presentations arising from this research

Publications

Douglas, J. (2014). Early career registered nurses: how do they stay? *The Hive*, 5(Autumn), 32 - 33.

Presentations

Douglas, J. (2016). *Nurses stories and the power of now: capturing the past to inform the future*. Paper presented at the Australian College of Nursing National Forum, Melbourne.

Douglas, J., & Bourgeois, S. (2018). *Telling stories: Using narrative as a research method*. Paper presented at the 6th Annual Worldwide Nursing Conference (WNC 2018), Singapore

Certification

I, Jane Alison Douglas declare that this thesis, submitted in fulfilment of the requirements for the conferral of the degree of Doctor of Philosophy, from the University of Wollongong is wholly my own work unless otherwise referenced or acknowledged. This document has not been submitted for qualifications at another academic institution.

Jane Alison Douglas

4 April 2019

Abbreviations, tables, figures and boxes used in this thesis

Acronyms used in this thesis

Acronym	Full terminology
ACT	Australian Capital Territory, Australia
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
ANCC	American Nurses Credentialing Centre
ANMAC	Australian Nursing and Midwifery Accreditation Council
AUD	Australian Dollar
CIT	Critical Incident Technique (Flannagan, 1954)
CPD	Continuing Professional Development
CST	Critical Social Theory
ECRN	Early Career Registered Nurse
EN	Enrolled Nurse
HWA	Health Workforce Australia
ICN	International Council of Nurses
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales, Australia
NT	Northern Territory, Australia
OECD	Organisation for Economic Cooperation and Development
QLD	Queensland, Australia
RN	Registered Nurse
SA	South Australia, Australia
SAO	Situation, Action, Outcome
TAS	Tasmania, Australia
TLT	Transformative Learning Theory
US\$	American Dollar
Vic	Victoria, Australia
WA	Western Australia, Australia
WHO	World Health Organization

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Glossary of key terms

Term	Definition
Australian Institute of Health and Welfare	Health, welfare and statistics agency for Australia.
Australian Nursing and Midwifery Council of Australia	Independent accrediting authority for nursing and midwifery education in Australia.
Enrolled Nurse (EN)	In Australia ENs are registered with the Nursing and Midwifery Board of Australia (NMBA). They are educated through the vocational education and training (VET) sector. Students must complete an NMBA approved Diploma of Nursing to be eligible to register as an EN (Australian Nursing and Midwifery Accreditation Council, 2017).
Identity	In this study, the term identity refers to a synergistic whole that is formed by the construction and interweaving of the ECRNs frames of reference. In line with constructivist ideas, identity is seen as the perception of the individual, not a judgment to be made by others.
Nursing and Midwifery Board of Australia	Regulating authority for nursing in Australia.
Registered Nurse (RN)	In Australia, RNs are registered with the NMBA. To be eligible to apply to register as an RN, a program of study, approved by the NMBA must be completed (Australian Nursing and Midwifery Accreditation Council (ANMAC), 2012). These are referred to as entry to practice or pre-registration programs. In Australia these programs may be at Bachelor or Masters level and are listed on the NMBA list of approved programs of study (NMBA, 17 August 2016e). Once registered, RNs must continue to meet NMBA registration standards (NMBA, 11 August 2015) and work according to their professional codes and guidelines (NMBA, 7 February 2017b).

Skill mix	The term 'skill mix' describes the mix of grades, posts or occupations in an organization (Buchan & Dal Poz, 2002). In an age of nursing shortages skill mix is often the force driving the model of nursing care adopted in a clinical area (Duffield, Roche, Diers, Catling-Paull, & Blay, 2010) taking into consideration the '... unique knowledge and skills that individual health care providers bring to their role' (McGillis-Hall & Buch, 2009, p. 5).
Transformative learning	'May be defined as learning that transforms problematic frames of reference to make them more inclusive, discriminating, reflective, open and emotionally able to change' (Mezirow, 2009, p. 22). It can be understood as the epistemology of how adults learn to reason for themselves rather than accepting and acting on the assimilated beliefs, values, feelings and judgements of others as '...it is not so much what happens to people but how they interpret and explain it that determines their actions, hopes, their contentment and emotional wellbeing, and their performance' (Mezirow, 1991, p. xiii).
Workplace experience	Workplace experience is defined by the Australian Nursing and Midwifery Accreditation Council (ANMAC) as the 'component of nursing education allowing students to use judgement when applying theoretical knowledge in an actual practice setting. It includes the concept of 'clinical training' as embodied in the National Law' (ANMAC, 2012). In Australia workplace experience is referred to by a variety of terms including clinical placement, professional placement, workplace learning and so on and is dependent on the University offering the qualification. For consistency in this thesis, the term workplace experience is used as defined by ANMAC.

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Prologue:

The story of Ezri: a parable

It was beyond dark - black as pitch. Darker he thought than blindness and like nothing else he had ever experienced. He could see nothing... nothing. Vision was impossible. It was cold but still and there was a smell of dampness ... hanging. There was a sense of something, of what? The waiting and the blindness heightened the sense of expectancy. Or was that fear? He could still hear a low murmur, building ... building to an intense hum almost like chanting, like a swarm of wasps in the distance, but this was close. He didn't want to reach out, he didn't want to move, if he stood still he would be safe, unnoticed. And if he did stretch out, who knows what he might touch. But in the blackness, in his blindness he felt his balance compromised and had to use his arms for balance. A voice in his head told him to be calm but his heart raced...

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Chapter One. Setting the scene: introduction

The title of this study is 'Early career registered nurses: How and why do they stay? Exploring their disorienting dilemmas' and a narrative approach has been used to address this question. In this chapter, I will provide an overview of the study including a brief introduction, background to the research, its purpose and an outline of the organization of the thesis.

Wallander is a dark and psychologically challenging drama, adapted for television and set in a sparse, bare landscape outside Copenhagen. As I watched the final episode, Wallander, the protagonist, becomes increasingly conscious of his spiralling trajectory into memory loss due to advancing dementia. In one of the last scenes, set in an Ibsenesque landscape, Wallander stands on the beach under a cold, grey sky, looking out to sea, trying to make sense of what he is experiencing. Reminiscent of Hamlet, Wallander speaks to the ghost of his father, who died of dementia years before. He says, 'It's just moments now... they don't join up ... My memories ... my life doesn't join up ... I can't remember' (Harness & Mankell, 2015). His father replies, 'Someone else will remember ... someone will remember for you' (Harness & Mankell, 2015). This study is about remembering for others, attempting to join the memories and make sense of experiences.

In this study I examined and analysed the threads running through and across the stories of 13 ECRNs, investigating the question, 'How and why do they stay?' The stories tell of the disorienting dilemmas faced by this group and their decision to remain working as

registered nurses (RN) despite or due to their disorientation. Transformative learning theory, first posed by Mezirow (1991), and grounded in constructivism, provides the guiding philosophical framework and the perspective from which the study is viewed. Identifying the perspective is essential to set the scene and providing readers with the context. This theory speaks of a process of perspective transformation linked to a person's perceptions. The situation faced by the great artist, Monet, demonstrates the importance of perspective. As Monet aged his deteriorating eyesight resulted in changes to his perception of certain colours, consequently affecting his ability to interpret and paint that which he saw. This deterioration presented Monet with a disorienting dilemma regarding how to manage his failing eyesight; conservatively or with surgery, eventually deciding on the latter (Steele & O'Leary, 2001). Following cataract surgery and the use of prescribed spectacles, Monet was again able to see colour (although to see it differently) allowing him to continue to paint up until his death in 1926 (Steele & O'Leary, 2001). While to me his later paintings are no less beautiful than his early works, the changes to his perception are noticeable, requiring the viewer to stand further back from the work to visualise the subject and make meaning of the picture. Both Wallander and Monet faced states of significant disorientation. Wallander questioned who he was and who he was becoming and Monet's view of the world was altered, leading to depression and the belief that he would be unable to continue painting. As each became conscious of different ways of thinking and doing, rather than seeking answers that were absolute, a sense of hope emerged through transformed perspectives. This study does not look for absolutes but instead seeks to discover how others make meaning through their perceptions and how, as adults, those perceptions and thus perspectives are transformed.

Rationale

I have worked as an RN for over twenty years with an ongoing interest in how nurses make sense of their experiences and how it contributes to their learning, particularly concerning their work. Nursing shortages affect the workforce at all levels including at the point of care. Over the last few years, I have watched as colleagues, particularly those new to the profession, choose to leave nursing or, who are seriously considering where else they can seek employment. Working in intensive care units (ICU) and palliative care areas I recall spending many hours on the phone trying to fill immediate shifts or those for the coming days, often to no avail and resulting in permanent staff having to work double shifts. Working a double shift in ICU usually meant working an afternoon and a night shift commencing at 1.30pm and finishing at 7.30am the next morning – eighteen hours in total. Added to this was the requirement that the RN arrive at 3 pm that afternoon, to work their rostered shift – this was a frequent occurrence happening up to twice a week for many staff.

Shortages of registered nurses are occurring globally and locally, with shortfalls predicted to increase. While the issue is complex, the literature suggests three main reasons for shortages. Firstly, the limited number of people attracted to becoming RNs, secondly, the attrition of RNs from the workforce and thirdly, economic and demographic changes that mean increased demand for nursing services (AIHW, 2016; Buchan, Schaffer, & Catton, 2018; World Health Organization, 2014). The RN shortage has implications for the health, safety and wellbeing of those interacting as consumers of health care (patients and clients) and those providing healthcare, including the RNs who remain in

the workforce. Buchan et al., (2018) suggest a need to identify, develop and implement multipronged approaches that not only attract people to the profession but also retain them once in the workforce.

While there is a plethora of literature regarding the recruitment, attrition and retention of RNs generally, there was a gap in the literature around the experiences of RNs in their first five years of practice; ECRNs. During this period there is an increased likelihood that RNs will signal their intent to leave the profession (Rudman, Gustavsson, & Hultell, 2014). This study significantly contributes to the literature by investigating how this underrepresented group makes sense of their experiences and how that leads to their decision to stay working in the profession.

Retaining nurses, particularly those with experience has numerous benefits, and this study listens to and shares the voices and experiences of a group of ECRNs who have chosen to stay, learning from them what led to their decision.

Purpose of the research

The purpose of this research was to contribute to the body of knowledge addressing the retention of ECRNs in the profession of nursing, asking how and why they stay, filling an existing knowledge gap. Thus, this study aimed to:

- a. Explore the stories of a group of ECRNs analysing their disorienting dilemmas to discover how they lived through them and the learning that occurred and led to the decision to stay.
- b. Investigate the motivating factors concerning why ECRNs stay working in the profession of nursing.

Organization of the thesis

This thesis consists of eight chapters, that work together to put forward the research undertaken. This chapter, **Chapter One**, *Setting the scene: introduction*, serves as an introduction to the study, providing a helicopter view that includes the aim of the research, the question, the rationale and the way the thesis should be read.

In **Chapter Two**, *Standing in the landscape: my ontology*, I acknowledge that as humans, past experiences shape the way we think and act and recognise that engagement in research is not exempt from our own experiences. It is recommended that qualitative researchers recognise that they are a part of the world in which their enquiry takes place, identifying the values, beliefs and previous experiences they bring to the enquiry (Jootun, McGhee, & Marland, 2009; Walsh, 1995). To this end, **Chapter Two** presents my ontology as it pertains to and impacts on this enquiry and together with the evidence discussed in Chapter Three, adds to the context and background of the research. This chapter explains how I came to the research question highlighting my being conscious of standing within the landscape where the research occurs.

In **Chapter Three**, *Engaging with the evidence*, I look to the relevant evidence including the literature, policy, discussions and other applicable material to investigate the question of how and why ECRNs stay. I will focus on two primary areas of investigation. The first explores evidence relating to the nursing workforce with a focus on the nursing shortage in the global and Australian contexts and retention of RNs and ECRNs in the workforce. The second area is the educational pathway and transition from student to

RN and the formal education of nurses in Australia and then the concept of lifelong learning which occurs before, during and after pre-registration education.

In **Chapter Four**, *Framing the study: guiding philosophical and theoretical principles*, I put forward and discuss in detail the philosophical and theoretical principles that frame the study based on the theory of transformative learning first posed by Mezirow (1991). I provide a background to transformative learning theory including, its evolution, processes and elements and explain its application in this study.

In the first part of **Chapter Five**, *The research design*, I comprehensively elucidate the qualitative research design used in the study, describing and explaining the chosen narrative approach. I set out the application of the methodology including ethical considerations and the seven-step process for the collection, creation and analysis of the stories in the second part of the chapter. Methods to ensure credibility and trustworthiness in the research process are also discussed.

In **Chapter Six**, *Strands and threads: the collective narrative*, I describe the findings from the analysis of the stories created from the interview transcripts of 13 ECRNs living and working in Australia. The chapter looks to the collective narrative of the thesis, identifying and discussing the strands and threads that emerged in and across the stories of the ECRNs, relating it to the relevant evidence. Despite their interdependence, the strands and threads have been collected and addressed in three main areas namely, disorienting dilemmas and challenges; how they stay and; why they stay. This organization was used to highlight the relationships to the research aims and for ease of discussion.

Chapter Seven, *The fabric of the thesis: the themes*, builds from Chapter Six demonstrating a deeper level of analysis of the findings. In this chapter I move to a discussion of the themes formed by weaving together the strands and threads discussed in Chapter Six. Five themes were identified, that when woven together form the fabric and overarching story of the thesis. The themes include: threats to identity; intersubjective relationships and dialogue; becoming authentic; altruistic intent and; human connection. This chapter discusses the themes and links them to the world and nursing that exists beyond these pages.

In **Chapter Eight**, *Conclusion, implications and recommendations*, I summarise the way the purpose and aims of the study have been achieved. I also highlight the implications for practice, education, learning and transitions of ECRNs, which are then reflected in the recommendations. I suggest areas for future research as well as the limitations for the present study concluding with a final reflection.

Reading this thesis

The use of the terms *patient* and *client*

Patient and *client* are used throughout the thesis and reflect the terms used by the participants. When participants referred to the patient it was usually to describe a person who was in hospital or a more acute setting. The term client was used by participants working in mental health or rehabilitation settings. I considered changing all terms to client but decided that the term reflected the way stories had been conveyed, deciding to let the terms remain.

The parable

A parable was written to reflect the themes of the study. The parable sets the scene, forming the prologue and unfolds with the themes of the thesis, appearing throughout Chapter Seven. The Epilogue brings the parable together as a whole, as the thesis concludes. The names of the characters in the parable are significant. Ezri comes from the Hebrew, and means 'my helper' or 'my supporter' (Hebrew Names, ND). Alfrida originates in the old English and means elf counsellor (BabyNamesPedia, ND). Throughout history, both have been used as names for males and females (BabyNamesPedia, ND).

A parable does not seek to provide answers but rather create an experience in the reader, triggering questions and thoughts. Parables are associated with numerous religious, spiritual and cultural traditions including but not confined to Judaism, Christianity, Buddhism (Slater, 1968) and Confucism (Li & Wegerif, 2014). Slater (1968) suggests a parable 'is a heuristic device designed to make the hearer decide on the application of the policies expressed in the parable to his own situation' (p. 25). In Confucian education the use of parables is not dissimilar, providing a dialogic and relational method of teaching. The questions raised in response to parables and the answers to those questions may differ depending on the need being addressed (Li & Wegerif, 2014); in this way they transcend the specific.

The parable was written following the identification and explication of themes and involved being in the three-dimensional inquiry space; moving inward, outward,

backward and forward (Clandinin & Connelly, 2000) through the thesis and the stories of the ECRNs. In this way the parable also represents the iterative nature of the study. The parable tells the story of the thesis, moving with it and beyond it, and while the characters in the parable exist within a context, they are situated beyond the particular. It aims to provide the story of the thesis while transcending its confines, releasing it to the broader fabric of society, beyond these pages to where nurses exist; in and of the world, across many settings and with others.

Conclusion

In this chapter I have introduced the topic of the thesis, including the research question and the purpose and aims. The way in which this thesis has been organized has also been conveyed. The following chapters will offer a detailed description of the background and context for the present study. This is done by presenting the values and beliefs I bring to the research through my own ontology (Chapter Two) followed by an in-depth exploration of relevant evidence surrounding issues relating to the nursing workforce and adult learning (Chapter Three).

Chapter Two. Standing in the landscape: my ontology.

Introduction

Connelly and Clandinin (2006) suggest that,

People shape their daily lives by stories of who they and others are and as they interpret their past regarding these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful ... to use narrative inquiry methodology is to adopt a particular view of experience as phenomena under study (p. 477).

Researchers are advised to embrace their humanness by commencing their research with the data of their own experience thus providing a context and a lens to the way the research is approached and viewed (Walsh, 1995). In this way, it is suggested that researchers recognise that they are a part of the social world under study (Jootun et al., 2009) acknowledging the importance and becoming aware of the values they bring to an enquiry, including their unique background, values and identity, and its impact on the research process (Polit & Beck, 2012). Recognising personal perspectives may prevent bias or transference but also present an advantage during interpretation of stories given that findings are a co-creation between participant and researcher (Jootun et al., 2009). In this chapter, I seek to position myself within the research landscape of this study. In keeping with the transformative learning which guides this study, I look at perspective frames and the assumptions that impact what I do as a human, nurse, educator and researcher.

Cranton (2001) urges us to understand who we are by firstly examining the perspectives we hold about ourselves and asking what it is that makes us the person we are and secondly, to consider how we came to see ourselves in that way because 'we cannot separate our sense of self from our experiences' (Cranton, 2001, p. 16). The way we see our experiences largely define the world we know. The way we make meaning of who we are comes from those experiences and determines our habits of mind; that is our assumptions, beliefs, values and perspectives. Cranton (2001) suggests that one way of doing this is by identifying the significant moments in life and thinking about why they are significant, reflecting on where values and assumptions come from. For me, events are significant because of the relationship they bear to the contexts in which they sit; the people, the places and the things that were happening at the time and the way transformation unfolds. This is how I recall my significant events, not so much as single moments in time but rather the unfolding and intertwining stories about my own learning and development, although the disorienting dilemma was often a moment in time that set the ball rolling.

My most significant learning usually started with a disorienting dilemma. This chapter does not list all the disorienting events I have experienced. Like me, the list will grow, develop and change, as being human is always about becoming (Scanlon, 2011).

The significant experiences in my life can be broken down into three main areas of being and becoming. All evolve from firstly being human;

- ◆ *Being human*: a daughter, partner, parent and friend which is my life before, during and beyond a career

- ◇ *Becoming a learner and consciousness raising*: It was in my experience as a student, undertaking and continuing study at university that I saw myself as a learner. It was a chosen path which I was privileged in my ability to access.
- ◇ *Becoming a nurse and being in the world*: My work as a nurse and an educator has taken several twists and turns and have been significant parts of my life.

Although not necessarily single events they contain the experiences that help to define who I am at the time of writing and in relation to this study.

My life experiences stretch across a variety of settings and contexts. Experiences bring both meaning and value but also establish boundaries. These areas of experience form and demonstrate the values I hold and are the basis of my identity at this point. Identity is always developing, and frames of reference and perspective are provisional as knowledge changes (Mezirow, 1994; 2012). As contexts change and new ones are experienced, my frames of reference and perspectives continue to form and transform. One element does not exist as separate from another; identity cannot be cut neatly into pieces but is added to the whole and to who I am and the way I act. They influence the way I approach new experiences such as the role of researcher and the framing of this study but also the interactions with others including the participants I interviewed and will be discussed in turn.

Being human

Growing up in a capital city in Australia in the 60's, 70's and 80's, and membership of the middle-class white culture influenced the construction of my frames of reference and my

perspectives; this is undeniable. I have been privileged in my access to education and a safe environment in which to live and the material goods that allow me to live a comfortable life. I inhabit many roles for example; I am a daughter, a sister, a friend, a partner, a mother, a nurse and a learner. These roles and the experiences associated with them influence and shape my identity and at some level provide me with a sense of who I am and the way I view the world and how I perceive the world views me.

My perceptions influence, not only my approach to learning but those with whom I am in contact. I aimed to model and share with my children a love of learning and the way education can change the course of life. I came to understand that facilitating learning and the excitement of learning was a significant gift that could be given to help my children find meaning as women and men of the future. It became increasingly important to me to share my values about learning and education with my daughter as a way of encouraging her to become an independent woman, who did not have to rely on the chance of marriage to support her in coming to know who she was in the world. For nurses working in a female-oriented occupation, this I believe is vital. While the work of nursing is relational and based on working with teams, nurses must be able to make sense of their situation, of what nursing is, without relying on other professions to define it.

Becoming a learner and developing consciousness

As a twenty-something, and encouraged by my partner, I decided to attend university and enrolled in a Bachelor of Arts degree to study English literature, history and sociology. The story was something I learnt to love as a teenager, especially fiction in the form of text and film. Story provided an escape from the everyday realities of life but also a way

of connecting back into reality and the quest for meaning through cautionary tales and metaphor presented in the literature.

I had not enjoyed my senior years at school and felt locked in and an unwilling participant in authoritarian approaches to teaching and learning which relied heavily on didacticism and the collection and regurgitation of facts. Learning in that environment meant reading, summarising and remembering textbook chapters on subjects that I did not find interesting or relevant. Many learners associate learning with boredom or lose the impetus to learn because of the way they experienced learning (Dewey, 1963). Looking back, I was probably a challenging student, argumentative and seemingly lacking motivation to learn the content of the given curriculum – I would not have liked to be my teacher!

Entering university proved to be a life-changing decision. I distinctly remember complaining about the assignments I had to complete, reverting to previous behaviours and attitudes toward education practised during my schooling. During one of these rants, someone said to me ‘...Well leave, no one is forcing you to go to university.’ This comment stopped me in my tracks. It was a consciousness-raising event that changed the way I thought about university and learning. I thought about that statement, at first thinking it harsh but then coming to a new understanding of myself and the assumptions that underpinned my approaches to education and learning. As a school student, I was not presented with a choice about going to school – legally I had to go. As a female, in a middle-class Australian family, university education was not encouraged, seen as unnecessary for females and meant there was little relevance associated with attending

school. Growing up, the belief in my household was that women worked until they married, hopefully well and then had children. This was an assumption that I had grown up with and did not really question until leaving home to marry.

Luckily for me, my partner, an educator, did not share this view and encouraged me to pursue my education and love of English literature at university. In realising I could leave university if I wanted to, I had a new understanding of my attitudes and beliefs. It was through this seemingly simple statement and reflecting upon it that my perspective transformed. Attending university was my choice, and yes, I could leave if I wished but of course there were consequences associated with that decision. On further reflection, I came to understand I was afraid of failing, of not doing well. I was the first in my pre-marriage family to attend university and a female. It was upon accepting responsibility for my decisions and deciding to remain at university that I learned to love learning. By becoming aware of new ideas and points of view, engaging in dialogue with people interested in and questioning similar things, my view of the world broadened, became richer and more intense. This love of learning and learning how to think about things invested in me an evangelical zeal and desire to instil a love of learning in others to facilitate their journey to know more about themselves by exploring other ways in which to think about things.

Coming to story

Studying literature from many cultures including the well and lesser known authors from the past and the present, helped me to understand the way stories and thus history are human constructions existing within a specific context and viewed from a particular perspective. To understand the story, it was essential to understand the context in which

the story was set and the way that people were writing at the time, and sociology and history helped me to do this. In learning about the importance of context I was also learning more about myself and the importance of my context to the way I thought, acted and viewed the world. As Mezirow states, 'reflection enables us to correct distortions in our beliefs and errors in problem solving. Critical reflection involves a critique of the presuppositions on which our beliefs have been built' (Mezirow, 1990a, p. 1). Having grown up in a world of authoritarian approaches, age and status equalled wisdom, and it was right and respectful to listen to and believe your elders, who would *give you the right story* which should be accepted as the absolute and unquestioned truth. Developing an understanding of constructivism (Candy, 1989; Raskin, 2002; Schunk, 2004; Young & Collin, 2004) and the way history is assembled, helped me to appreciate that the things we see, hear and read are from a certain viewpoint, are provisional and that there is no *ultimate truth*. It was through this consciousness raising, another of my assumptions was debunked. The telling of history is from one perspective but there must be acknowledgement that many truths exist, and each telling represents one of those, although truths can be shared. It is in the interpretation and evaluation of existing evidence, points of view, opinions and other forms of evidence that a provisional reality can be discovered and '[w]hen we subsequently use this interpretation to guide decision making or action, then making meaning becomes learning' (Mezirow, 1990a, p. 1).

During my Arts degree, I enrolled in creative writing which was challenging but liberating, and the learning experienced was not that which I had imagined. I did not become a famous author, nor top the class but learnt much about myself and my place in the world and the importance of trying to understand and accept the views of others. In

constructing stories, I came to understand the way they helped to reveal the assumptions of the author. I could take a story where I wanted it to go, creating worlds that could instruct, entertain and bamboozle. The emancipation of the story and listening to others interpretations of it, offered ways of knowing about who I was. It taught me much about being an author and the omniscient and God-like role it offered and about the way truth is constructed. In the sharing of my stories with others and the worlds created within the confines of the text, that story world was set free, making it available for others to access and interpret in ways beyond my control or imagining.

In the first instance receiving feedback at university had been difficult and although my marks were fine, initially I was devastated by negative comments and critique. Engaging in creative writing, allowed me to see that stepping away from my work, distancing myself from it, provided an objectivity to accept the feedback that peers and lecturers offered. It was not me being critiqued but rather the story, the created world. Moving beyond the assumption that critique of my work was personal criticism was a transformative experience and important in my ability to move forward. By sharing stories, they become a part of the world of others and thus a way of examining my frames of reference, born out in the way I wrote the story which helped me to identify and explore my assumptions and how they affected my view of the world. This impacted the way I now offer feedback to others about their work which is offered with respect, honesty and care, focussing on the work but not devaluing the person or their experience as a learner. This attitude was one that I carried with me when working as an educator and facilitator of learning and into this study as I listened to the stories of participants.

Human beings narrate past events and experience throughout their lives for a diversity of reasons some of which include giving information, sharing thoughts and feelings, justifying their actions or beliefs or by way of giving meaning to their experience (Holloway & Freshwater, 2007, p. 703).

In this study I sought to find meaning rather than solutions and often encountered more questions. I have much to thank those University educators for, particularly during the early years. I learnt much about literature, history and sociology but most importantly I learnt how to think about things and as such how to reflect and work toward making sense and meaning from experience. Using story and narrative is the way I have approached this study based on my experiences of reading, interpreting and seeing the power that storytelling offers because 'to be human is to tell stories' (Clark, 2010, p. 3).

Studying education was another milestone and a turning point in my life. The study of education opened new understandings and ideas and it was during this time that I was introduced to the theory of Transformative Learning (Cranton, 2002; Mezirow, 1981, 1990a, 1994, 1996b, 1997; Taylor, 2008) and the writings of Mezirow, Cranton, Taylor and others. This theory centres on critical reflection, dialogue and experience. The process begins with one or a series of disorienting dilemmas and for me this resonated. Over time it has become the philosophy that underpins my approach to teaching and in my own reflection as a nurse, educator and a person. The use of this theory as the framework for this study was appropriate as it feels authentic and fits beautifully with the use of story and with nurses who are tellers of stories. The decision to use a qualitative research design was based on the appropriateness of the method for the study (Jootun et al., 2009). Nurses tell and share in the stories of others as part of our practice

(Bangerter, Mayor, & Doehler, 2011; Haigh & Hardy, 2010) and as such it seemed a natural fit to use one of the ways nurses communicate as the method for this study.

Becoming a nurse: being in the world

I completed a Bachelor of Nursing (BN) in the early 1990s in Australia, not too many years after nursing education had moved to the University from the hospital setting and away from the apprenticeship model of training. I completed a three-year BN studying fulltime. During that time nursing was transitioning to a profession. One element of this evolution was establishing nurse education within the university system, supported by the hallmarks of a profession including a specialist body of knowledge, ongoing research, a code of ethics, autonomy and professional organizations (Berman et al., 2012; Willetts & Clark, 2014). This transition was about the developing identity of nursing.

The BN curriculum I studied included extensive content on the historical and philosophical foundations of nursing including the impact of society and politics on health. Classes involved philosophical debates about the art and science of nursing and focussed on the holistic approaches to healthcare as opposed to Cartesian models (Pierson, 1998) and as I practised nursing I came to value that learning. Many of these concepts or historical content are no longer included in nursing curriculums or at best only mentioned briefly (Lewenson, 2004; Madsen, 2008; McAllister, Greenhill, Masden, & Godden, 2010) as more technologically driven agendas take their place. Nursing history is more than the mapping of where the profession has been (Lewenson, 2004) but is also about developing the Profession of Nursing's sense of identity (Lynaugh, 1996). Madsen (2008) argues that learning nursing history offers students a sense of identity by

expanding historical consciousness and explaining the way the past shaped the present and helps to develop critical thinking. 'Social identity has an important role in developing a society. A society without identity has low self-esteem, has underdeveloped ethical reasoning, suffers from serious interpersonal problems, is not faithful to its values, and depends on alien identity' (Yazdannik, Yekta, & Soltant, 2012, p. S178) which may go some way to explaining nursing's attempts to imitate the medical approaches to care and research (Hills & Watson, 2011). The historical stories of philosophers, patients and other nurses fascinated me, and I saw how my Arts education linked to my nursing study and practice and provided a fuller view of the profession and the context in which it sat. Nurses must not lose their history; it helps them to know who they are, where they have come from and where they are going. This study and the stories it draws from will be become a part of nursing's history and should not be cast aside.

As a nursing student, I juggled full-time study, with working as an assistant in nursing at a local nursing home, being a partner and the mother of young children. We moved from one town to another at the end of my second year, which meant transferring universities to complete my degree undergoing yet another transition. One of the lecturers in the new institution said to me that transferring at this stage must be very difficult to which I remember replying, 'If I can do this, I can do anything', a phrase I have used on many occasions since. What I discovered was that I could do it, and upon reflection, can see the close connection between motivation, identifying the relevance of study and the need to evaluate the consequences of choices which required a certain pragmatism – if I wanted to be a nurse, and be with my family, this was what I had to do. It also reflected the adult learning principles espoused by people such as Knowles, Holton, and Swanson

(2011), Mezirow (2012), Cranton (2001) and others. Like all learning, there was a choice, and it was imagining the consequences of those choices that helped me to make that and future decisions.

Following graduation and like the participants in this study, I had my own experience of being a new graduate, registered nurse and working in different types of workplaces. As a registered nurse, I have been fortunate in the opportunities afforded me and the support offered. I have worked in clinical, community, educational and regulatory roles and settings. This diversity allowed me to learn what it is to work as and with other nurses, experiencing the disorientation that results in the transition from one role to another and experienced what it is to be in the world as a nurse.

Working as a nurse, meant meeting people from diverse backgrounds. It was a colliding of lifeworlds, listening to, sharing and becoming a part of the stories of others and realising the need to evaluate my concept of *normal* which was based on the frames of reference formed as a result of my upbringing and limited experience of the world and others. Slowly I learned that normality was a social construction, not a constant or absolute and what I had heard about in sociology was becoming a reality – the pieces began to fit together. The only normal was the diversity that existed, and if I was to nurse effectively, I needed to be able to accept diversity. It was not until working as a nurse I truly understood the need for acceptance through listening to the stories of others, being moved, sometimes shocked and often pushed beyond my zone of comfort and knowledge. This meant having to face my assumptions about the world which were based on my limited experience. This also meant learning about empathy which involves

the capacity to hold conflicting viewpoints with appreciation and respect (Taylor & Elias, 2012).

Beckett (2011, p. 58) suggests that 'identities are shaped by what we do and what we normally do is relational. It is simply in our doing that we find our being.' While agreeing with this statement in principle, I would take it further and suggest it is also in *thinking* about *what has been done*. It was in this that I started to understand the power of reflecting on actions when attempting to make sense of experience. Through reflection I realised that to be a nurse meant accepting that I was always *becoming* a nurse, as things around me changed and my thoughts and perspectives transformed.

Being an educator and facilitator of learning

I have studied, taught and worked in the area nurse education for several years commencing with studies in adult education. It was in this space that I came to explore and understand the importance of learning relationships (Cox, 2015) and the transformative power that learning offers, through becoming conscious of self, resulting in 'the ability to be both different from and the same as others in a purposeful way' (Cranton, 2016, p. 72). In understanding self, social and organizational transformation is possible (Brookfield, 2012; Freire, 2000). Working with adults to develop their approaches to learning by exploring who they are and who they are becoming is an area of work which has brought much satisfaction. Adding to and facilitating the learning of others and observing students transform into professionals who think critically and work in person-centred ways has been a privilege. I have watched budding professionals grow into fully fledged registered nurses, and it is heartening to see the impact they have on people and the health care system as they develop into skilled and thoughtful RNs. It is

always inspiring to run into an ex-student and hear what they are doing five or ten years on. It is saddening though, when they tell me that they or their peers have decided to leave the profession (and there have been many) because of how they were treated by colleagues or the demands placed upon them by the health care system, seeking options where co-workers were kinder on their mental health and self-esteem. It has been my own experience and listening to the experiences of others over a period of 25 years that led me to a point where I felt compelled to investigate and make sense of the research question in this study 'ECRNs: How and why do they stay? Exploring their disorienting dilemmas'

Conclusion

This is a part of my story, contributing to my ontology and as with any story it is a selective construction. Stories offer not only a recollection of experience they also offer an experience to the reader. Committed to paper my story assumes a stability or stasis but paradoxically it is also filled with the potential to lift from the page and intertwine with the reader's story as they identify points of connection, where ideas grow and develop, questions emerge and as different perceptions and interpretations are laid across and through it. The opportunity as a novice researcher to investigate nursing and the role of learning using a narrative approach has allowed the integration of three areas that hold deep significance to my learning and forming a story about the way ECRNs make sense of their experiences. The following chapter will investigate the evidence pertinent to the research question. Subsequent chapters will explore transformative learning theory and define its use as the philosophical framework and the narrative approach used as a methodology in this study.

Chapter Three. Engaging with the evidence

This study investigates the issue of how and why ECRNs stay working, examining the way they work through and make sense of their disorienting dilemmas. The previous chapter looked inward to my ontology and its implications for this research. This chapter looks outward to the evidence, exploring relevant and appropriate research, policy, standards and discussion to provide a rationale and direction for this study, focussing on the nursing workforce and the retention and factors leading to a shortage of RNs. The study uses a transformative learning theory as the philosophical framework, acknowledging the key role of learning in the ECRN journey from student to RN and throughout their early career. It will be this path that will be fully elucidated in this thesis.

Background

On average, healthcare workers make up ten percent of the workforce in countries belonging to the Organisation for Economic Cooperation and Development (OECD) (OECD, 2017; United Nations High-Level Commission, 2016). Between 2000 and 2015, the percentage of people employed in the health industry has steadily increased by an average of 42 percent across OECD countries with predictions that this trend will continue (OECD, 2017, p. 148). According to the World Health Organization (WHO) (2016), approximately 50 percent of the global health workforce comprises of nurses and midwives. In most countries, including Australia, nurses are the largest group of health care providers and are at the forefront of the health care industry (Health Workforce Australia (HWA), 2013; 2014; International Council of Nurses (ICN), 2006; OECD, 2017). In 2015, there were an estimated 43.5 million healthcare workers worldwide of which,

20.7 million were nurses and midwives, 9.8 million were physicians, and there were approximately 13 million other health care workers (WHO, 2016) placing into context the size and potential influence of the global nursing workforce. The size of the nursing workforce, however, does not reflect an even distribution across countries, and the number of nurses per 1000 population varies from 0.078 in Somalia in 2014 to the highest ratio in Monaco, who, in 2014, reported employing 20.521 nurses for every 1000 population (WHO, 2018b). In 2016, Australia reported 12.566 nurses per 1000 population, ranking it in the highest ten countries who had supplied data (WHO, 2018b). The WHO (2018b) data includes midwives, and it is unclear how nurses holding joint registration or licensure are represented in this data. This information provides a broad overview of where ratios apply across a country but may not reflect distributions of nurses within countries, for example the distribution in rural or remote areas compared to urban or regional areas.

Globally, the health workforce is experiencing shortages, and more than 50 percent of the current shortage comprises of nurses and midwives (WHO, 2016). WHO predicts that by 2030, the world will require an additional nine million nurses and midwives. To meet those demands, WHO (2016, 2018a) suggests current strategies to train, educate and employ RNs will be insufficient to produce numbers to meet the demand (WHO, 2016; 2018a). Many OECD countries have increased the number of places available for pre-registration education in Schools of Nursing attempting to increase the number of nursing graduates to help meet shortfalls (Buchan et al., 2018; OECD, 2017). Buchan et al. (2018) stress however that this strategy alone is inadequate, and propose finding strategies to retain nurses is of equal importance.

Nursing shortages in the global context

It is acknowledged that to meet the needs of healthcare consumers, an adequate and effective nursing workforce is essential (Buchan et al., 2018). Threatening the workforce capacity threatens the delivery of safe and effective health care (ICN, 2006). Nurses play a crucial role in the provision of health care across areas, including in the acute and primary health care settings (ICN, 2006; OECD, 2017). OECD countries face increasing shortages of registered nurses related to increased demand for nursing services and the attrition of RNs from the system (AIHW, 2016; Buchan & Aiken, 2008; Buchan, Duffield, & Jordan, 2015; Buchan et al., 2018; Commonwealth of Australia, 2014; Currie & Hill, 2012).

There are several reasons for an increased demand for RNs including an ageing population, escalations in complex and chronic conditions and the expansion of community and primary health care services (Aggar, Gordon, Thomas, Wadsworth, & Bloomfield, 2018). It is also predicted the demand for RNs will increase due to the broadening scope of practice into advanced roles in attempts to increase consumer access to health care (Buerhaus, Des Roches, Dittus, & Donelan, 2015). Increased attrition of RNs from the system is predicted due to age-related retirements as well as voiced intentions to leave the profession for other reasons (See table 3.1 for reasons and examples of research). The intent to leave the profession was highlighted in a multi-country, multi-centre, cross-sectional analysis of survey data involving 23 159 nurses across 10 European countries and 385 hospitals (Heinen et al., 2013). The results indicated that of the 23 000 nurses working on medical surgical wards across 10

countries, overall nine percent of the nurses surveyed signalled an intention to leave the profession within the following year. The figures suggest between a five to 17 percent variation across the 10 countries of RNs signalling an intent to leave (Heinen et al., 2013). The reasons for considering leaving nursing varied between countries, and included factors related to work environment, staffing ratios, burnout and perceived quality and safety of care, a lack of involvement in decision making, issues related to leave access, shift work and pay, increased patient expectations and poor staff attitudes and workplace culture (see Table 3.1 for reasons for leaving and examples of published research in the area).

The combination of RN attrition and increased demand for nursing services suggests the need for strategies that not only attract people to the profession and but also retain them in the workforce. Buchan et al. (2018) advise that the challenges and strategies associated with nurse retention are contextually driven and therefore require strategies that are multilevel, combined with policy development that is relevant to particular settings rather than the imposition of universal solutions.

Retention of RNs in the workforce

Professional turnover refers to nurses leaving or planning to leave the profession which is different to organizational turnover when nurses move between workplaces (Currie & Hill, 2012; Parry, 2008). Professional turnover is a significant issue and should be a priority for nursing managers and health care administrators as it is costly, and has the potential to negatively affect morale and stress levels for remaining staff (Buchan et al., 2018; Buchan et al., 2015).

Reason for leaving	Author / Researcher
Stress and burnout	Boamah & Laschinger, 2016; Chan, Tam, Lung, Wong, & Chau, 2013; Chang & Hancock, 2003; Day, Crown, & Ivany, 2017; Dotson, Dinesh, Cazier, & Spaulding, 2014; Gardiner & Sheen, 2016; Heinen et al., 2013 Laschinger, Wong, & Grau, 2012; Rudman, Gustavsson, & Hultell, 2014
Poor Workplace Cultures, staffing ratios and lack of managerial support	Arslan Yurumezoglu & Kocaman, 2016 Dawson, Stasa, Roche, Homer, & Duffield, 2014; Flinkman & Salanterä, 2015; Mills, Woods, Harrison, Chamberlain-Salaun, & Spencer, 2017; Tuckett, Winters-Chang, Bogossian, & Wood, 2015
Bullying and incivility	Duffield, Roche, Blay, & Stasa, 2011 Mammen, Hills, & Lam, 2018; Purpora & Blegan, 2015; Rhee, Hur, & Kim, 2017; Sauer & McCoy, 2018; Trepanier, Fernet, Austin, & Boudrias, 2016; Brewer, Kovner, Obeidat, & Budin, 2013 Vogelpohl, Rice, Edwards, & Bork, 2013
Feeling undervalued, disempowered and lacking in decision making / autonomy	Dawson et al., 2014 Sprinks, 2012
Job satisfaction	Flinkman & Salanterä, 2015 Goodare, 2017
Retirement, health reasons	Allen, Fiorini, & Dickey, 2010; Chenoweth, Jeon, Merlyn, & Brodaty, 2010; Dotson, Dave, Cazier, & Spalding, 2014; Heinen et al., 2013; OECD, 2017; Roche, Spence-Laschinger, & Duffield, 2015; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010
Increased demand for nursing services	Buerhaus, DesRoches, Dittus, & Donelan, 2015

Table 3.1: Reasons why nurses leave and examples of research.

The issue of professional turnover leads to the discussion of retention of RNs in the workforce. The positive outcomes of retaining RNs are many and include addressing the projected shortages, fiscal savings, personal wellbeing of RNs remaining in the system, patient safety and quality of care (Banks & Bailey, 2010; Buchan & Aiken, 2008; Buchan et al., 2018; Hinson & Spatz, 2011; Smeds-Alenius, Tishelman, Runesdotter, & Lindqvist, 2014). RNs leaving a health care organization affect costs and productivity and ultimately access and availability of services and the quality of care (Buchan et al., 2018). Attrition also impacts negatively on the workloads and working conditions of those RNs that remain in the system (Buchan et al., 2018).

A comparative review of turnover rates across four countries demonstrated significant costs associated with turnover of staff and ranged from US\$20 561 in the USA, to US\$48 709 in Australia (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014) (See Figure 3.1).

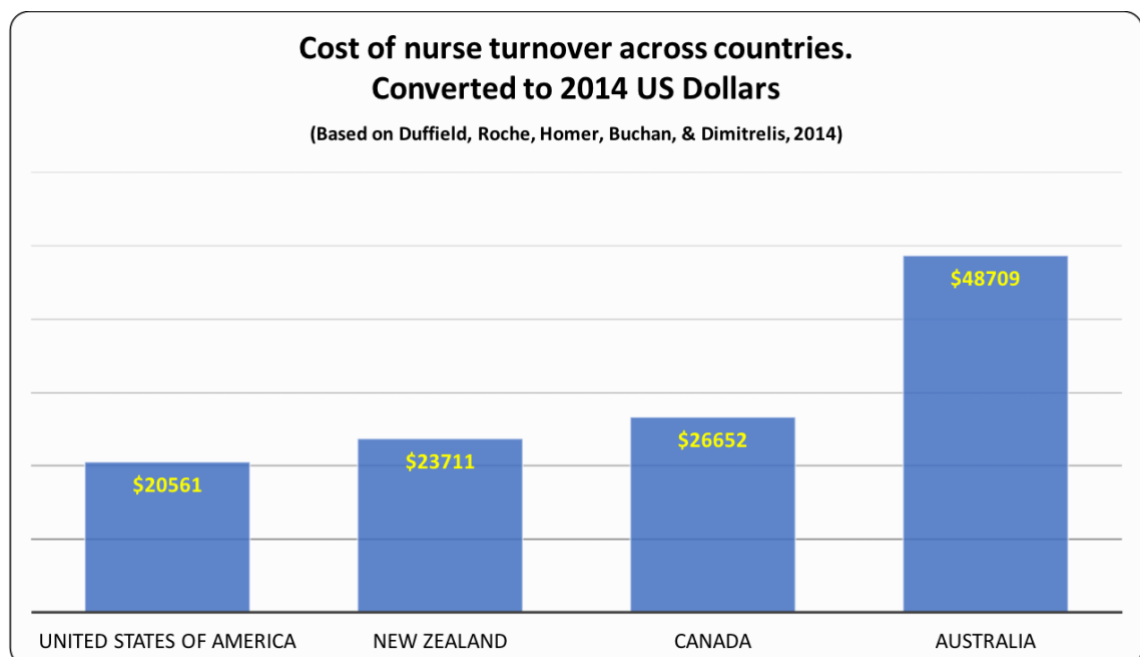


Figure 3.1: Cost of nurse turnover across countries (USD).

These figures include the cost of replacing nurses, paying for temporary replacements and the orientation and education of new and temporary staff (Duffield, Roche et al., 2014). Hogan, Moxham, and Dwyer (2007) found the turnover of nurses in the United States in 2000 was 21.3 percent, which has staffing and economic implications because employing a new staff member may cost as much as twice a nurse's salary and this has been further supported in an Australian study by Hayes et al. (2012). In a later study, Roche, Spence-Laschinger and Duffield, (2015) collected data from 62 general wards situated in 11 Australian hospitals across three states using the nursing turnover costs calculation methodology (NTCCM). 1673 nurse surveys were completed. The annual turnover rate per ward was 15.1 percent overall and costs (in Australian Dollars) ranged between \$68 621 in the Australian Capital Territory (ACT), \$58 260 in Western Australia (WA) to \$26 199 in New South Wales (NSW) with the overall average cost being \$49 255 per full time equivalent staff member. These were the most recent figures available, despite searches across data bases (including SAGE, Science Direct, Scopus, Wiley Online, ProQuest Central & Google Scholar). As with Duffield et al., (2014), the calculation of cost included the hiring, education and training and they found that temporary replacement was the largest single cost related to nurse turnover (Roche, Duffield, Homer, Buchan and Dimitrelis, 2015, p. 355).

Suggested strategies for retaining RNs have included improving and maintaining job satisfaction, stress reduction, value congruence (Dotson, Dave, Cazier & Spalding, 2014) and improving individual resilience and self-concept of the individual (Mills, Woods, Harrison, Chamberlain-Salaun, & Spencer, 2017). Improving retention and decreasing attrition of RNs is complex and multifaceted, and must be considered in context to avoid

attributing blame or shifting all responsibility to individuals for issues that occur at systemic levels and are beyond the control of the individual (Oliver, 2017). For example, it is simplistic at best to suggest an individual can simply become more resilient or use resilience to counter bullying or aggressive behaviour from a supervisor or to manage political or systemic issues; this denies the complexity of work environments and those who populate them and shifts responsibility to the individual. Samra (2019) goes so far as to suggest that expecting people to build resilience may in fact have the opposite effect of helping them to cope by adding further to performance pressures and expectations.

Retention of experienced RNs is associated with better and safer patient outcomes (Bartel, Beaulieu, Phibbs, & Stone, 2014; Chenoweth, Merlyn, Jeon, Tait, & Duffield, 2014; Kutney-Lee et al., 2016; Smeds-Alenius et al., 2014; Trepanier, Fernet, Austin, & Boudrias, 2016) and provides supervisors, mentors and preceptors for those with less experience and upon which they can model ways of working (Benner, Sutphen, Leonard, & Day, 2010). Buchan et al. (2018) suggests a paucity of research into the links between nurses leaving organizations and the provision of quality of care but points to evidence from magnet hospitals who demonstrate lower turnover rates and job vacancies, higher levels of job satisfaction amongst employed RNs as well as lower mortality rates compared to control hospitals. Magnet hospitals are recognised by the American Nurses Credentialing Center (ANCC) as having met the requirements of the Magnet Recognition Program®. To do this the hospital must address and meet the five Model components (See figure 3.2). To be awarded Magnet status organizations must demonstrate successful alignment of nursing strategic goals to improve patient outcomes and

To nurses, Magnet Recognition means education and development through every career stage, which leads to greater autonomy at the bedside. To patients, it means the very best care, delivered by nurses who are supported to be the very best that they can be (American Nurses Credentialing Centre, NDb)

The conditions in magnet hospitals reportedly lead to higher recruitment and retention of experienced and well qualified nurses who can provide consistent quality through a stable and experienced workforce (Buchan et al., 2018).

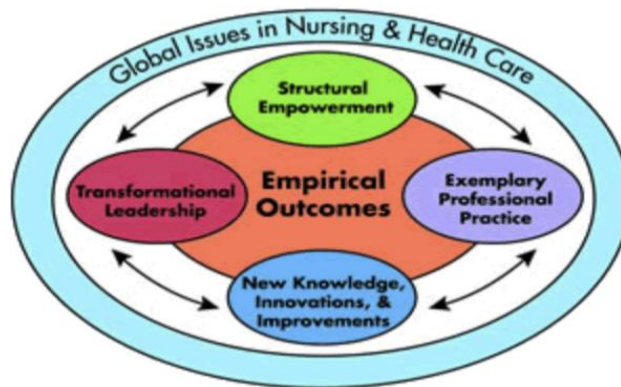


Figure 3.2: Five Model Components and forces of magnetism framework. American Nurses Credentialing Centre, NDa)

The Australian context

The nursing profession is the largest, single health profession in Australia (HWA, 2014). In September 2018 the Nursing and Midwifery Board of Australia's (NMBA) registrant data listed 289 038 registered nurses across Australia. The largest group of registrants according to age are between 30 to 34 years (13%), followed by the 55 to 59 year age group (12%) (NMBA, September 2018a) (see figure 3.3). The majority of RNs in Australia

work in New South Wales (NSW), Victoria (Vic) and Queensland (QLD) (see figure 3.4)

These distributions align with state populations.

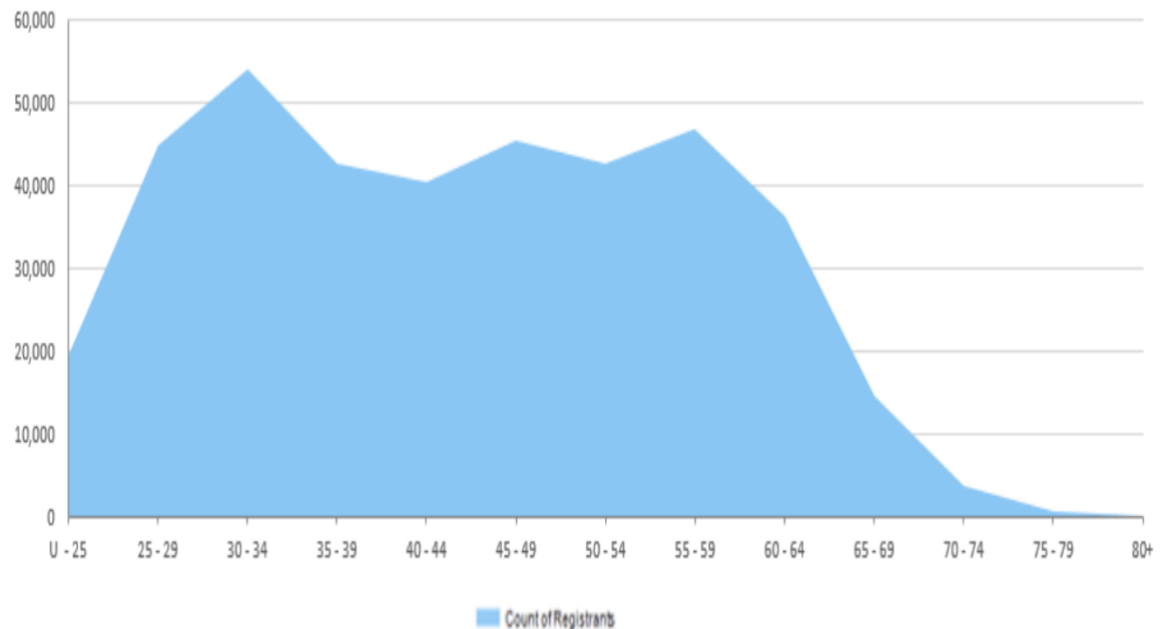
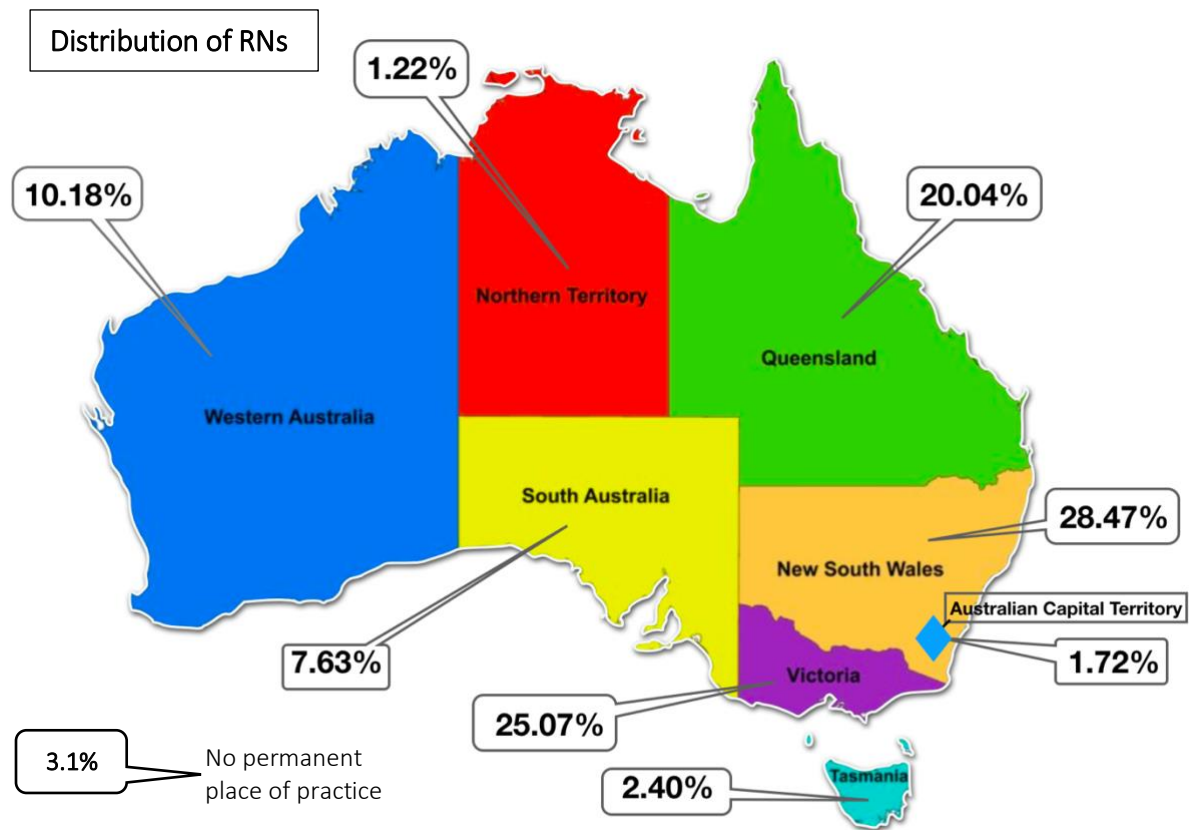


Figure 3.3: General RN registration by age (NMBA, 2018a).

The report does not provide specific information regarding areas of work or the number of years since entering the register.

As in other OECD countries, Australia is experiencing nursing shortages. Nursing shortages are defined as the gap between the current or projected requirements and current or projected demand for staff (Buchan et al., 2015) and these are predicted to continue to worsen over coming years (Mills et al., 2017; National Health Workforce Taskforce, 2009; NSW Nurses and Midwives' Association, 2018; WHO, 2014).



Map of Australia retrieved from <http://nbdayun.me/provinces-of-australia-map/>

Figure 3.4: Percentage of general registration (RN) by principal place (Australian state or territory) of practice (Data: NMBA, 2018a)

The reasons for current and projected nursing shortages in Australia are well documented and similar to other OECD countries (for example, AIHW, 2016; Buchan & Aiken, 2008; Commonwealth of Australia, 2014; Doiron, Hall, & Jones, 2008; Duffield, Baldwin, Roche, & Wise, 2014; Duffield, Roche, Blay, & Stasa, 2011; Duffield, Roche et al., 2014; Hayes et al., 2012; Mills et al. 2017; OECD, 2017). The reasons include an ageing and retiring workforce, where the average age of registered nurses in Australia is 45 years (Buchan et al., 2015) and changing economies and demographics that continue to drive the demand for registered nurses (Dotson et al., 2014). Added to this are the impacts of

stress, workplace cultures and the treatment of RNs by others in the workforce, particularly of those their early years of practice (Mills et al., 2017; Rudman et al., 2014).

Projected nursing shortages in Australia have been revised and reduced, attributed in part to economic factors like the Global Financial Crisis, resulting in nurses postponing retirement (Dotson et al., 2014; HWA, 2014; OECD, 2017). The predicted shortfall however, remains significant (Dotson et al., 2014) and Buchan et al. (2015) warn that shortages are already occurring, signalling that the issue must not be trivialised or ignored.

This study focusses on ECRNs registered with the Nursing and Midwifery Board of Australia (NMBA) and working in Australia. The NMBA (2017c)

...undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

The process leading to registration and work in Australia as an RN is worthy of discussion here to provide context. Those wishing to become RNs in Australia for the first time must have completed a program of study leading to registration and they must meet all NMBA requirements (NMBA, 2017b). Organizations offering nursing education leading to registration as an RN, must have their pre-registration education curriculums accredited by demonstrating that they meet the registered nurse accreditation standards (Australian

Nursing and Midwifery Accreditation Council (ANMAC), 2012) and be approved by the NMBA. Currently, in Australia, entry to practice programs leading to registration as an RN are offered at Bachelor (Australian Qualifications Framework (AQF) level 7) or Masters (AQF level 9) levels (Australian Qualifications Framework Council, 2013). Under the Health Practitioner Regulation Law Act (National Law) (Office of the Queensland Parliamentary Counsel, 2009) and in the interests of public safety, universities must register all nursing students with the NMBA for the duration of their pre-registration education (Australian Health Practitioner Regulation Agency (AHPRA), 2014). In Australia, pre-registration preparation of RNs must ensure that graduates have met the registered nurse standards for practice along with other requirements set out in the educational standards (NMBA, 2016b).

The current RN educational standards (ANMAC, 2012) require a combination of theoretical, simulation and workplace learning and each student must complete at least 800 hours of workplace experience (in Australia this is also known as clinical placement/practicum, work integrated learning, professional experience, workplace learning and other terms specified by the education provider) which is supernumerary, supervised learning in a variety of health care settings where RNs work (ANMAC, 2012). Although registered with the NMBA, nursing students are not RNs, and learning aims to assist students imagine what the RN role might entail and how they might function and apply skills and knowledge once registered and working in the RN role. This learning focusses on the imagined self, negotiating possible selves that can be trialled before becoming fully fledged professionals (Vu & Dall’Alba, 2011). While imagination is an essential element in learning (Cranton, 2016; Illeris, 2014b; Jarvis, 2006; Tisdell, 2012),

and instrumental in helping to construct a person's frames of reference and consider alternatives, it is and can only be that – imagining – which requires translation when moving from the imagined to the experienced as ECRNs commence their new role.

Early Career Registered Nurses (ECRN)

In this study, an ECRN is an RN who has been registered for up to and including five years. ECRNs in their first year of practice were excluded from participating in this study as there is a plethora of research investigating the experiences of that group. The term ECRN has been used increasingly in recent years and while some definitions include nurses in the first two years of practice (Australian Nursing and Midwifery Federation (ANMF), 2018) this study includes RNs who have been working for up to and including five years (Douglas, 2014; Flinkman & Salanter, 2015; Mills, Chamberlain-Salaun, Harrison, Yates, & O'Shea, 2016; Price, 2016; Wang, Tao, Bowers, Brown, & Zhang, 2018; Mills et al., 2017).

It is suggested that nurse attrition in the first five years of practice is significant (ANMF, 2018) however figures to support this could not be found. Kovner, Jun, Brewer and Fatehi (2014) warn that the reasons and terminology surrounding turnover in nursing are complex and should be used with caution. This makes sense when considering the problems associated with gathering these figures including the need to find and approach ECRNs once they have left the system or accessing confidential exit information that might be kept by organizations. There is however evidence to suggest that ECRNs are at increased risk of leaving the profession in their first five years of practice. This is understood through studies investigating ECRNs intent to leave nursing (Chan, Tam, Lung,

Wong, & Chau, 2013; Ellenbecker, Samia, Cushman, & Porell, 2007; Heinen et al., 2013; Kovner, Djukic, Fatehi, Fletcher, Jun, Brewer & Chacko, 2016; Mills et al., 2016; Mills et al., 2017; Parry, 2008; Sauer & McCoy, 2018; Rudman et al., 2014; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010). One such Swedish study demonstrated increasing numbers of RNs expressing an intention to leave the profession across their first five years of practice (Rudman et al., 2014), and it was this study that helped to define the five year inclusion criteria of participants for this study. Rudman et al's., (2014) longitudinal, observational study followed 1417 nurses through the first five years of their career discovering that the intention to leave the profession increased dramatically over that time (see Table 3.4), and by five years post registration every fifth participant expressed a strong intention to leave the profession, with the main predictor being burnout (Rudman et al., 2014).

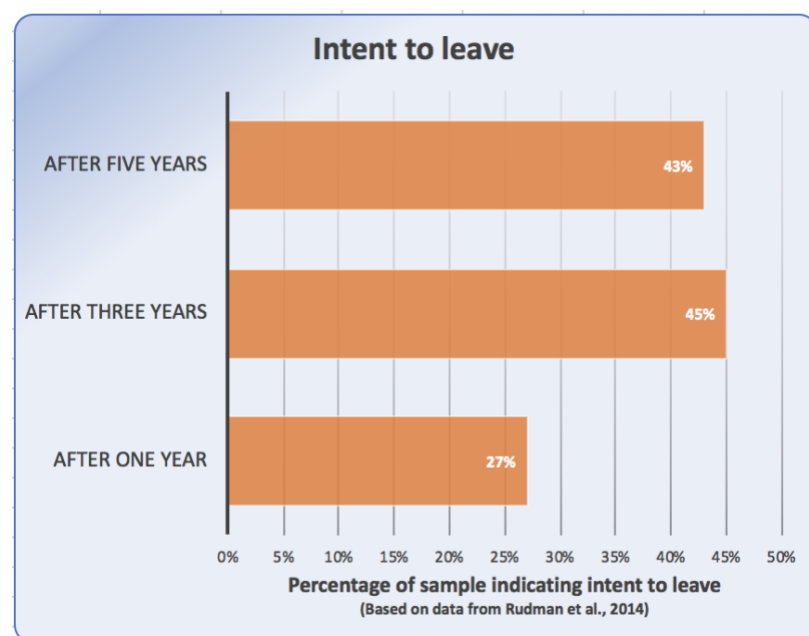


Figure 3.5 Intent to leave in the first five years of practice

While the decision to leave the profession is often multifaceted (Duffield, Pallas, & Aitken, 2004), intention to leave is a strong predictor of actually leaving (Blau, 2007). Rudman et

al. (2014) recommended that further investigation is needed to shed light on the transition from education to practice particularly professional development and overall functioning in the workplace.

Although ECRNs in the first year of practice were excluded from participating in this study it is worth mentioning some of the issues that have surfaced in the literature for graduate nurses in the first year of practice, especially given that all participants had experienced that transition. Numerous studies explore the experience of newly graduated nurses in their first year of practice (for example, Cowin & Hengstberger-Sims, 2006; Crow, Smith and Hartman, 2005; Mooney, 2007a, 2007b; Parker, Giles, Lantry, & McMillan, 2014). Mooney's (2007b) investigation into the experience of new graduate nurses used a grounded theory approach and interviewed 12 newly qualified Irish nurses. Through thematic analysis, the study found that '...the transition of nursing students to professional nursing practice have been acknowledged as being traumatic and stressful' and that most of the nurses who participated in their study 'felt frustrated, vulnerable, stressed and disappointed post qualification' (Mooney, 2007b, p. 75). Mills et al. (2016) found that ECRNs searched for quality career advice and suggested consideration regarding the rotational structure of transition to practice programs (TPP) in Australia. A further Australian investigation used a cross-sectional design and administered questionnaires to 161 ECRNs from one hospital in Australia. The results revealed self-concept, practice environment and resilience, factored in the retention of ECRNs (Mills et al., 2017). There is however limited documented evidence that deals specifically with the experience of ECRNs after their first year of practice in Australia.

The need to increase the number of undergraduate students enrolling and completing nursing degrees is well documented (Benner et al., 2010; Buchan et al., 2018; Hogan et al., 2007; WHO, 2016). Consequently, the number of government-supported places in pre-registration programs in Australia has increased over recent years with the NMBA reporting increases in student registrations of 2.8% (92 145) in 2017 (NMBA, 2017a) and 4.8% (96 753) in 2018 (Australian Health Practitioner Regulation Agency (AHPRA), 2018). While this situation will assist in addressing the predicted nursing workforce requirements in coming years (Gaynor, Gallasch, Yorkston, Stewart, & Turner, 2006) it is also essential to consider the retention of RNs (Bartel et al., 2014) to avoid a revolving door to employment, meet shortages and take heed of studies recommending the retention of experienced RNs because it leads to better patient outcomes (Allen, Fiorini & Dickey, 2010; Hayes et al., 2012).

Nurses leaving the profession has staffing and economic implications for the health system (Buchan et al., 2018; Douglas, 2014; Duffield et al., 2004; Duffield, Roche et al., 2014; Heinen et al., 2013; Hogan et al., 2007; OECD, 2017; Rudman et al., 2014; United Nations High-Level Commission, 2016). Rafferty and Clarke (2009) conclude that more data about less senior nurses and their experiences is necessary and we need to ask the question, ‘...What are the characteristics of those nurses who have survived the system?’ (p. 877). To this end, in this study, I inquired ‘How and why do ECRNs stay?’ rather than why they leave. Studies about retention tend to infer that if the reason nurses provide as to why they leave were addressed, then the outcome would be that they would stay, begging the question, is this necessarily the case? By asking questions about how and why ECRNs stay in the nursing workforce, we can begin to understand their approaches

to disorienting dilemmas, including the characteristics, methods and resources used to make sense of their experiences. In this way we can begin to understand and develop strategies to retain future ECRNs. This investigation presents an opportunity and a starting point to suggest ways, strategies and resources to assist in the education and support structures for all current and future ECRNs and facilitate their transition to and through their careers with the aim of retaining their experience in the workforce.

ECRNs' learning

In this study, learning is seen as central to making meaning, and all humans are learners. RNs in Australia are expected to be lifelong learners and this is made explicit in the RN standards for practice at Standard 3.3 which states that the RN 'uses a lifelong learning approach for continuing professional development of self and others' (NMBA, 2016b, p. 4). Further to this RNs must also be able to demonstrate completion of 'a minimum of 20 hours' of continuing professional development (CPD) per registration period (NMBA, 2016a, p. 2). A discussion of ECRNs as adult learners is warranted here to provide context to the transformative framework used in this study.

Becoming an RN involves significant learning, and this informed the choice of a transformative learning theory which guides the study. This theory is discussed in detail in Chapter 4 and throughout the thesis. In brief, transformative learning theory is a theory of adult learning first posed by Jack Mezirow (1991). At a fundamental level, the theory proposes that learning is about experiencing change and the way people respond, adapt and make meaning from it. The transformative learning process is initiated by a disorienting dilemma, leading to dialogue and critical reflection offering the possibility of

perspective transformations. While learning is something that happens to the individual (Jarvis, 2014), Merriam and Bierema (2014) remind us that learning takes place in a context that is social. In transformative learning, awareness of context is a core element (Illeris, 2014b) but the processes leading to transformation, transcends particular contexts (Taylor & Jarecke, 2009) and this is especially relevant to ECRNs as they learn about who they are becoming from and with others.

Underpinned by constructivist approaches, transformative learning theory suggests learning helps people make meaning of experience (Merriam & Bierema, 2014) and that it is social and relational (Belenky & Stanton, 2000; Cranton, 2016; Cranton & Taylor, 2012). This view acknowledges that humans do not learn in isolation but rather from, with and about each other and that learning can occur anywhere and everywhere and extending across the lifespan (Cranton, 2016; Jarvis, 2006; The Taos Institute, ND). Learning is not confined to formal education, which due to its institutional nature has restrictive barriers and boundaries (Jarvis, 2006). If learning occurs anywhere, everywhere and at any time, it stands to reason that the local and broader context in which it occurs, will impact it. Such factors include individual, cultural and socio-political determinants and the way people in the workplace interact, the policies that govern learning, access to funding and how learning is viewed and approached (Brookfield, 2012) across settings.

For adults, their experiences define who they are (Merriam & Bierema, 2014). This sense of definition is important because in situations and environments where learners' experiences are perceived as rejected, devalued or ignored, the adult learner may

interpret this as a rejection of them as a person (Knowles, Holton, & Swanson, 2011). Such rejection is particularly significant for the adult in a new position or role who is learning to 'be' in that world. Of adult learners Cranton (2016) suggests

Regardless of the context, adult learners are mature, socially responsible individuals who participate in sustained informal or formal activities that lead them to acquire new knowledge, skills, or values; elaborate on existing knowledge, skills, or values; revise their basic beliefs and assumptions; or change the way they see some aspect of themselves or the world around them (p.2).

The process of learning is concerned with what happens in the learner's head, heart, body and soul and that may result in changes to behaviours or attitudes (Merriam & Bierema, 2014). Learning also involves the relationship and interaction between the individual and the world (Bevis & Watson, 1989) and concerns the whole person (Dewey, 1963; Jarvis, 2014).

Perpetual change is central to adulthood and may prompt an identity crisis and challenge relationships and a person's sense of legacy (Merriam & Bierema, 2014). Constant change exists in society (Mezirow, 1990a; 2012) including within the health care system at all levels (Day, Crown, & Ivany, 2017; Hills & Watson, 2011). Changes may occur in a client's status and new treatments through to the seemingly constant restructuring of the systems that support health care in Australia (Davidson & Everett, 2016). Learning to question assumptions helps individuals learn about themselves and how to cope with expected and unexpected changes; by understanding self and questioning underlying assumptions, individuals can learn how they react to change across contexts and situations (Cranton, 2016; Mezirow, 2012). Some changes may lead to transformative

learning and a change in 'our way of thinking and being in the world' (Merriam & Bierema, 2014, p. 253) where adults learn by making meaning of their life situations, reorganizing their thinking in ways that may result in a change in beliefs and then behaviours (Cranton, 2016; Cranton & Taylor, 2012; Illeris, 2014; Mezirow, 1991; 2012).

Lifelong learning

Dewey (1963) reminds us the belief that a person learns only the thing they are studying at the time is a pedagogical fallacy and what is most important to development is the desire to go on learning. He suggests there is no good in learning a set of skills,

...if in the process the individual loses his own soul: loses his appreciation of things worthwhile, of the values to which these things are relative; if he loses desire to apply what he has learned and, above all, loses the ability to extract meaning from his future experiences as they occur (Dewey, 1963, p. 49).

Formal university education in Australia often suggests that graduates will be lifelong learners and propose fostering the desire to continue to learn. Many universities in Australia embed the concept or notion of lifelong learning or lifelong learning skills into programs of study via their expected graduate attributes (for example, Australian Catholic University, ND; Charles Sturt University, 2019; Murdoch University, 2018). Bevis and Watson (1989) believe that education should develop learners who engage in the lifelong process of knowing self. As in the assessment made by Jarvis (2006) lifelong learning is far broader than formal, content driven education (Merriam & Bierema, 2014) and rarely occurs in isolation from the world in which the learner inhabits. Instead this approach to lifelong learning informs and is informed by the world (Jarvis, 1987), where learning happens, everywhere, anywhere and anytime, even when we are not conscious

of it (Jarvis, 2014). Jarvis (2006) suggests that the approach and application of lifelong learning concepts have been narrowed, moving away from Dewey's (1963) conceptions and now tend to focus upon workplace contexts rather than viewing it in the context of the whole of life. Jarvis' definition reflects a broad view that is ontological and where lifelong learning is,

The combination of processes throughout a lifetime whereby the whole person – body (genetic, physical and biological) and mind (knowledge, skills, attitudes, values, emotions, beliefs and senses) – experiences social situations, the perceived content of which is then transformed cognitively, emotively or practically (or through any combination) and integrated into the individual person's biography resulting in a continually changing (or more experienced) person (2006, p. 277).

Although speaking about professional learning, Benner et al. (2010) and Scanlon's (2011) views support Jarvis' in the belief that 'becoming' a professional cannot be reduced to the acquisition of knowledge and skills in the hope that graduates will seamlessly transplant these from the education to the work setting.

Preparing professionals

Scanlon (2011) makes the distinction between 'being' and 'becoming' a professional, suggesting that the use of the term 'being' implies an endpoint and therefore stasis which denies the evolutionary nature of the identity. The term 'becoming' is used to reflect the ongoing nature of learning and development and the constant cycles of change that exist within society and the health care system to which nurses need to adapt and evolve as they move through their careers. Vu and Dall'Alba (2011) suggest a need for authentic learning in the preparation of professionals. Authentic learning involves more than

students becoming familiar with situations through simulated environments or workplace experiences. Simulation is used widely in pre-registration nursing programs but there is limited evidence to suggest how well this type of learning translates into post-registration practice (Doolen, Mariani, Atz, Horsley, O'Rourke & McAfee, 2016). Authentic learning moves beyond simulation to facilitate students in becoming more fully human and is about

not only epistemology – what students are expected to know and be able to do - but also about ontology – learning about who they are becoming or, in other words, learning to be (Vu & Dall'Alba, 2011, p. 96).

In formal education, nurses learn the skills to carry out the work of a nurse, but they must *also become nurses*.

Scanlon (2011) recommends that the development of the learner is not a linear process but rather an evolutionary and iterative one. When knowledge and skills combine with professional performance, they help constitute identity, remembering that the 'professional self is an ever-changing phenomenon, never fully realised, always in the process of becoming other' (Scanlon, 2011, p. 14). One can work as a nurse through the completion of formal study and registration, but the process of becoming a nurse is ongoing and acknowledges the ever-changing environment and the individual's ability to learn, grow and adapt to external and internal changes. The ability to grow and adapt, is then, what constitutes lifelong learning; it is learning to be ourselves by learning about ourselves. This is what Jarvis is referring to when he suggests nurses must learn to live the role (Jarvis, 2006).

Conclusion

This chapter examined the evidence to demonstrate the need for investigation about how and why ECRNs stay working in the profession. Australia is not immune to the actual and predicted global shortages of RNs. Various reasons for the RN shortages have been explored and discussed, and centre on increasing demands for RNs because of demographic changes and attrition due to retirement and those leaving the system for other reasons such as burnout and stress. The significance of this study cohort gives ECRNs a voice in the discussion considering how we encourage them to stay, to harness their increasing levels of experience as they deliver safe and effective care and educate and mentor future ECRNs. RNs are at increased risk of leaving the profession in their first five years signalling the need for investigations into this situation. Retention of experienced RNs in the workforce is essential in meeting the ever-increasing demand for, and scope of nursing practice and this study acts upon the recommendations of Rafferty and Clarke (2009) to investigate how some RNs survive the system and the transition to practice. This chapter highlighted the complexity and multifactorial nature of why ECRNs signal an intent to leave, and the reasons how and why they stay, although the research concerning retention and attrition for this group is still limited. This chapter asserts that ECRNs learning, particularly learning about who they are as RNs, is central to making meaning of their experiences and functioning in the workplace. The centrality of learning was a guiding influence on the choice of transformative learning as a philosophical framework and is discussed in detail in the following chapter.

Chapter Four. Framing the study: Guiding philosophical and theoretical principles:

Introduction

A defining condition of being human is that we have to understand the meaning of our experience. For some, any uncritically assimilated explanation by an authority figure will suffice. But in contemporary societies, we must learn to make our own interpretations rather than act on the purposes, beliefs, judgments, and feelings of others (Mezirow, 1997, p. 5).

This study is informed by the way adults learn to exist, to be and to become, in new environments and new roles. Mezirow (2009) defines learning as ‘the process of using prior interpretation to construe a new or revised interpretation of the meaning of one’s experience to guide future action’ (p. 22). In this study I have used a theoretical and philosophical approach based on Transformative Learning Theory (TLT) (Mezirow, 1991; 1994; 1997; Mezirow, Taylor, & Associates, 2009) engaging in discourse to investigate how and why ECRNs remain working within the profession of nursing and the way they make meaning of those experiences by critically reflecting on the assumptions that underpin their identified disorienting dilemmas. The way ECRNs approach these events is explored together with those factors that helped them deal with disorientation leading them to form or transform their frames of references and perspectives. In this chapter, I provide an explanation of TLT and the way it is used in the study. I will also explore the foundations of TLT; its directions and influences.

Transformative learning

may be defined as learning that transforms problematic frames of reference to make them more inclusive, discriminating, reflective, open and emotionally able to change (Mezirow, 2009, p. 22).

It can be understood as the epistemology of how adults learn to reason for themselves rather than accepting and acting on the assimilated beliefs, values, feelings and judgements of others as

...it is not so much what happens to people but how they interpret and explain it that determines their actions, hopes, their contentment and emotional wellbeing, and their performance (Mezirow, 1991, p. xiii).

Mezirow draws from Habermas (1971, p. 3) to describe three ways of knowing; technical, communicative (or practical) and emancipatory, to explore how reliable knowledge is possible. Technical knowing involves the acquisition of information and content to manage one's world. Communicative knowing focuses on the interpretation of knowing to understand one's world, often from a particular position. The third way of knowing is emancipatory knowing and is based on critical reflection of assumptions and examines the reliability of one's knowledge. Critical reflection for Habermas, aims to attain knowledge through discourse, not merely from a given position but rather as a dynamic system of interactions between speakers and hearers, where two subjects encounter each other. This communication is what Habermas refers to as subject to subject dialogue (Habermas, 1984, p. 106). In TLT emancipatory knowing occurs through perspective transformation, where frames of reference and perspectives transform, and people are emancipated from the constraining ideas, values and judgements of a certain

individual or group position. An emancipatory level of knowing through perspective transformation is the concern of this study.

In this study, I used an approach and constructed a framework based on TLT. TLT centers on experience and the way people make meaning from experience; this is what I was seeking to investigate with the ECRNs I interviewed. It is a theory I have used for many years as an educator of nursing students, finding the approach relevant and appropriate to underpin the education of adults in workplace experiences, simulation and classroom settings. As a nurse, a parent, a child and a member of the community, the process of transformation as a result of disorientation is something I have witnessed in adults, including myself, existing beyond formal educational settings, whether because of the birth of a child, commencing university or facing illness and death. The transformation process is about trying to understand and make meaning of those experiences and the things that happen to us or to those with whom we are in relationship. In an interview with Mezirow, conducted by doctoral students in New York, he states that transformative learning can occur anywhere and is not dependent on formal learning structures or programs (Mezirow, 2015). Given that learning happens to the whole person (Illeris, 2014a, 2014b; Jarvis, 2006; Merriam & Bierema, 2014) this makes sense, as people learn in and from experience, and experiences happen everywhere and anywhere.

The central tenets of transformative learning; experience, discourse and critical reflection on assumptions (Mezirow, 1991; 2015) form the framework for the approach used in this study and the exploration of the disorienting dilemmas of ECRNs and learning how they make meaning through their experiences. These tenets will be discussed in due course

concerning the way they inform the study, but first I will explore the background to and influences on the TLT.

Background to Transformative Learning Theory

TLT (Mezirow, 1991) has its origins in research first presented by Mezirow and Marsick in 1978 when they investigated the experiences of women returning to education in adulthood (Kitchenham, 2008; Willis, McKenzie, & Harris, 2009). Their study found that adult learners may undergo a personal transformation as the result of discourse and critical reflection on assumptions (Mezirow, 1991; Mezirow & Marsick, 1978). From that research ten phases were identified that adult learners might encounter in the journey toward transformation (See Box 4.1), commencing with a disorienting dilemma and concluding with reintegration of the individual into life with new perspectives. In this study, I sought to learn about the disorienting dilemmas of ECRNs and explore their reintegration into life with transformed frames of reference and perspectives and how it impacted on their decision to remain working as a nurse.

Phases of Transformative learning
<ol style="list-style-type: none">1. A disorienting dilemma2. Self-examination with feelings of guilt or shame3. A critical assessment of assumptions4. Recognition that one's discontent and the process of transformation are shared, and others have negotiated a similar change5. Exploration of options for new roles, relationships, and actions6. Planning a course of action7. Acquiring knowledge of skills for implementing one's plans8. Provisionally trying out new roles9. Building competence and self-confidence in new roles and relationships10. A reintegration into one's life on the basis of conditions dictated by one's new perspective (Mezirow, 1991, pp. 168 - 169; Mezirow & Associates, 2000, p. 22)

Box 4.1: Phases of transformative learning

The assumptions that underlie TLT draw from constructivist approaches. The theory assumes that people participate in the creation of reality, consciously or subconsciously; this is a constant activity focussing on change. Construction of reality occurs within a context where the locus of control remains with the person but acknowledges intricate and reciprocal relationships between individuals and the world (Candy, 1989; 1991; Mezirow, 1991). TLT assumptions include and refer to the process by which individuals or organizations transform taken for granted frames of reference to be more able to guide future actions in a way that is authentic and truthful (Mezirow, 2000; Mezirow & Associates, 2000). Truthfulness refers to the truth based on the best available information at the time, developed through critical reflection and discourse; it is always provisional (Mezirow, 1991) and open to additional critical reflection. In this study, as in TLT, I apply the assumption that individuals and, in this case, ECRNs, construct meaning through their interpretation of experience in, with and about the world. Moreover, the construction of provisional truth occurs as a result of the ECRNs' frames of reference (See Box 4.2 for definitions used in TLT) that develop as a result of the historical, social, and psychological filters that form perceptions of experience (Mezirow, 2012).

Along with constructivism, the development of TLT was impacted by humanism and the work of theorists such as Maslow (1970) and Rogers (1969) who believed humans can make choices with the potential for growth and development and possess the ability to define their reality (Cranton & Taylor, 2012). In the 1960s, humanism became the prevailing philosophy in adult education and emphasised the way individual adults learn (Cranton & Taylor, 2012).

Critical Social Theory (CST) influenced Mezirow in the development of TLT (Mezirow, 1997; 1998a; 2003; 2012; 2015; Mezirow & Associates, 2000), predominantly the work of philosopher Jurgen Habermas (1984; 1989). Habermas' writing on communicative action and the importance of interactions among speakers and hearers rather than actions by certain groupings or individuals was an essential influence on TLT regarding the use of ideal conditions for discourse. CST was a significant influence on TLT and the examination of society rather than reducing it to only the individual (Cranton & Taylor, 2012; Kitchenham, 2008). This lens suggests that to effect change and particularly social change, people must first become conscious of the dominant hegemonies in society (Brookfield, 2003; Kitchenham, 2008; Taylor, Cranton, & Associates, 2012). Early adult educators such as Paulo Freire (2000) and Myles Horton (1990) focussed on social context and emancipatory learning in the belief that this could lead to freedom from oppression, something that during an interview, Mezirow commented, is always the role of adult educators (Mezirow, 2015).

Whilst this study is not about the debate that ensues regarding the difference between the ways adults and children learn, it is important to highlight its existence to contextualise the theory of transformative learning. Adult learning has been investigated for many years, spiralling through numerous philosophies (Illeris, 2014a; 2014b; Knowles, 1973; Merriam, 2001; Rogers, 1969). Positivist or behaviourist (Cohen, 1979; Skinner, 1974) approaches to studying learning focussed on the way chronological age affected the individual's speed and processing of information. Historically, behaviourist research methods compared the learning of adults to children's learning, and investigations

usually occurred in controlled environments that did not reflect the environments where adults learn (Merriam, 2008).

Becoming thinkers who are autonomous and responsible is an important long-term objective for adult learners and having,

the understanding, skills, and disposition necessary to become critically reflective of one's assumptions and to engage effectively in discourse to validate one's beliefs through the experiences of others who share universal values (Mezirow, 1997, p. 9).

Children often develop the foundational learning needed to think autonomously including recognition of cause and effect relationships, the use of informal logic, control of emotions, empathy and imagination to construct narratives and begin to think abstractly (Inhelder & Piaget, 2013). The ability to think hypothetically and critically, reflect on what is seen, heard, or read may begin to develop in adolescence (Ginsberg & Oppen, 1988; Inhelder & Piaget, 2013). In adulthood and with maturity and experience, the foundational elements of learning may gain strength and expand, where adults become more critically aware of the need to assess the assumptions governing beliefs, values, judgements, and feelings, recognise frames of reference and imagine alternatives (Mezirow, 1991; 1992). Adults are also 'more responsible and effective at working with others to collectively assess reasons, pose and solve problems, and arrive at a tentative best judgment regarding contested beliefs' (Mezirow, 1997, p. 9). Discourse and critical reflection provide the vehicle used to achieve this.

Becoming critically reflective of one's assumptions is the key to transforming one's taken-for granted frames of reference, an indispensable dimension of learning for adapting to change (Mezirow, 1997, p. 9).

Definitions used in Transformative Learning Theory

Meaning Schemes

Meaning schemes are 'sets of related and habitual expectations governing if-then, cause-effect, and category relationships as well as event sequences' (Mezirow, 1990b, p. 2). They include taken for granted associations made on a daily basis and implicit rules that direct understanding (Illeris, 2014b; 2014c) for example when we flick a light switch, we assume the light will turn on, and the room will be illuminated.

Frames of reference

Frames of reference are the results of ways of interpreting experience (Mezirow, 2012, p. 82). A frame of reference refers to the structure of assumptions that filter impressions involving cognitive, affective, and conative domains that shape and define perception. Frames of reference are composed of two dimensions: habits of mind and resulting points of view (Illeris, 2014a; Mezirow, 2012). Our values and sense of self, are embedded within our frames of reference. Mezirow (2012) states a frame of reference is a 'meaning perspective' (p. 82). The term frames of reference is used in this study.

Habits of mind and points of view

A habit of mind is a set of broad and generalised assumptions that may be conservative or liberal in orientation and act as filters and predispositions when interpreting the meaning of experience. Some varieties of habits of mind include sociolinguistic, moral, ethical, epistemic, aesthetic, psychological and philosophical (Mezirow, 2000). They may manifest as behaviours or preferences expressed as points of view (Mezirow, 2012). A point of view comprises clusters of meaning schemes that are specific expectations, beliefs, feelings, attitudes and judgements that implicitly lead and inform a specific interpretation about how causality is judged and attributed and objects are typified (Mezirow, 2012).

Assumptions

Assumptions are the things that are taken for granted, for example, religious views or cultural wisdom. Assumptions are related to the context in which they occur and include the intent which may be implicit (Mezirow, 2012).

Box 4.2: Definitions used in Transformative Learning Theory

Herein lies the difference between one who learns as a child and one who learns and thinks like an adult, suggesting the need for different ways of studying and distinguishing between child and adult learning.

Approaches to Transformative Learning Theory

Merriam (2008) acknowledges that the development of adult learning theory is dynamic and complex and not reducible to a single, simple explanation or interpretation. Like any theory, TLT has continued to develop and is under constant construction which Mezirow demonstrates through writings, conversations, and responses to critiques of TLT (for example Dirkx, 2012; Dirkx, Mezirow, & Cranton, 2006; Mezirow, 1989; 1996a; 1998b; 1998c; 2015; Mezirow & Associates, 2000). TLT reflects the complexity of learning in adults, and the engagement in discourse about his theory demonstrates what Mezirow (1991) espoused: that through discourse in the form of dialogue, participants seek consensus based on best available knowledge.

A dualism exists around the approaches that support either individual or social transformation (Cranton, 2006; Illeris, 2014b; 2014c; Taylor & Snyder, 2012). As discussed, the Humanist approach to learning regards the individual as the focus of growth, development and transformation. Theories of Humanism, as with TLT, attract criticism for not emphasising the importance of context and social change to learning. There are also comments that the theory is too cognitively reliant, failing to acknowledge other types of knowing, such as those found through spirituality (Dirkx, 2012) or art and music (Tisdell, 2012). Alternatively, those approaching TLT from the CST stance believe

that TLT does not emphasise strongly enough the effect the dominant social and cultural ideologies have on learning, proposing that when people transform their society, they transform their reality (Brookfield, 2003; 2005; 2012; Taylor & Snyder, 2012). Taylor (2008) points out that the boundaries between these two approaches are unclear asserting that

...there are a variety of alternative conceptions of transformative learning theory that refer to similar ideas and address factors often overlooked in the dominant theory of transformation (Mezirow's), such as the role of spirituality, positionality, emancipatory learning, and neurobiology. The exciting part of this diversity of theoretical perspectives is that it has the potential to offer a more diverse interpretation of transformative learning and have significant implications for practice (p. 7).

Clark and Wilson (1991) suggest that TLT recognises that learning takes place in social contexts but criticise the lack of focus placed on this element and the impact the 'inequitable social structure' has on learning and social transformation (Clark & Wilson, 1991, p. 78). Cranton and Taylor (2012) suggest both individual and social factors are evident in the works of Mezirow and the disconnect between critical social theories, constructivist and humanist perspectives are about the content of learning. Mezirow (2000) addresses this as different types of reframing; objective reframing (related to the external world) and subjective reframing (related to the self). Cranton and Taylor (2012) advise that TLT does not have to be exclusive to one approach but is about both, with each perspective providing elements that help in the continuing development a three-dimensional theory, reflecting the complexity of learning and what it is to be human.

In TLT meaning is constructed through experience and the perception of those experiences. This perception influences the view of future experiences, calling into question assumptions and uncritically assimilated perspectives (Cranton, 2006; Mezirow, 1991; Taylor & Snyder, 2012; Tisdell, 2012). The level of rationality in this process has been challenged as too limited (Ekpenyong, 1990) and has led to its evolution. Dirkx (2012) for example adopts a Jungian approach based on individuation, referring to a hidden, inner self or 'soul' formed by human emotions and personal myths as people construct their life. For Dirkx, it is through transformative learning that people seek to make meaning of outward expressions. These expressions are driven by the conscious and unconscious inner self where meaning-making moves beyond the rational and includes unconscious, imaginative and extrarational processes (Dirkx, 2012; Dirkx et al., 2006; Taylor & Snyder, 2012).

Further dimensions have been added to TLT in response to claims that it failed to explore the impact of human relationships on learning. There was also criticism that the significance of relational or connected transformative learning and trustful relationships were ignored (Belenky & Stanton, 2000; Cranton & Taylor, 2012; Taylor & Snyder, 2012). In later writings, Mezirow acknowledged that humans are 'essentially relational' (Mezirow & Associates, 2000) where

*... identity is formed in webs of affiliation within a shared lifeworld.
Human reality is intersubjective; our life histories and language are
bound with those of others (Mezirow, 2000, p. 27).*

The relational approach to learning involves individuals suspending judgment in an attempt to understand the viewpoints and perspectives of others with the aim of

observing situations holistically rather than analytically and is still about developing a better understanding of self through engagement with others (Taylor & Snyder, 2012). Cranton and Wright (2008) demonstrated this by using narrative enquiry, itself a form of discourse, to investigate the way literacy teachers foster transformative learning through relationships between educators and learners. Vieten, Amorak, and Schlitz (2006) argue that human consciousness can transform because of spiritual practices and experiences. Their qualitative research sought to identify common factors in the transformative process amongst teachers across different traditions. They found that the experience of interconnectedness and oneness may result in altruism and compassion leading to perspective transformation. The ability to cognitively and rationally respond to and explain transformation is what is available to researchers but does not necessarily deny the existence of other forms of knowing.

A disproportionate focus on rationality in TLT is questioned, concerning different ways of knowing and TLT has been criticised for a lack of discussion concerning the impact of emotions and feelings (Dirkx, 2012; Tisdell & Tolliver, 2001), society and context (Baumgartner, 2001; Brookfield, 2003; 2005; 2012), memory, spirituality (Tisdell, 2012; Tisdell & Tolliver, 2001) and where changes or learning occurs without conscious awareness. Modern techniques have enabled some of these areas to be explored through empirical methods. The use of advanced and less invasive imaging methods such as positron emission tomography (PET), medical resonance imaging (MRI) and single-photon emission computerised tomography (SPECT) has allowed research into the function of the human brain and connections to learning. Such technology has enabled demonstration of the interconnectedness between the brain and body and to show a

relationship to learning. This adds support to arguments about the interrelationship and interdependence between neural function and cognitive and emotional learning (Drevets & Raichle, 1998; Gerrod & Schulkin, 1993; Le Doux, 1992; Panksepp, 2003). These studies have implications for how a change in the frames of reference and perspectives might occur at neural levels and beyond conscious cognitive awareness (Taylor, 2001) and where learning as a result of discomfort is enhanced through sensory, kinaesthetic and emotive experiences (Taylor, 2001; Tisdell, 2012). The work of Newberg, Wintering, Khalsa, Roggenkamp, and Waldman (2010) using SPECT scans demonstrated a relationship between increased blood flow to the brain and improved cognitive function and the way different areas of the brain become active depending upon the type of auditory stimulus. Further to this, Siegal's (2010) work on neuroplasticity found that neurons and neural pathways continue to grow and develop throughout life not just during childhood as once thought which has implications for a person's ability to learn throughout life and supports theories of lifelong learning.

Different approaches to research and the study of TLT is essential not only because of the findings but to highlight the way different approaches contribute to the bigger picture or as Cranton and Taylor (2012) suggests, to reveal different parts of the elephant, that when integrated form a dynamic and holistic theory. Along these lines and based on emerging approaches to transformative learning theory, Cranton and Taylor (2012) highlight the need for and propose a more unified approach to TLT. They suggest that a unified approach would critique social and individual transformation and focus on the way different approaches complement each other, rather than on the way they differ, searching for consensus and recognising diversity.

The theoretical and philosophical approach used in this study adopts a more unified view to TLT acknowledging that people are of the world, intricately linked to and through their context and relationships. This study argues that people and their stories should not be removed from their context when attempting to make sense of their experience and uses narrative research to gather the stories of how ECRNs make sense of the experience of nursing. Learning through transformation happens to the whole person, and it is through the contexts to which individuals are exposed and belong that they consciously or unconsciously form, reform, and transform their frames of reference.

The process and elements of Transformative Learning Theory

The process of transformation in TLT begins with a disorienting dilemma (Mezirow, 1981; 1989; 1990b; 1991; 1994; 1995) which may be epochal (sudden realisation) or incremental (a series of events over time that lead to realisation). A disorienting dilemma serves as a catalyst, challenging a person's prior unexamined habits of mind (See Box 4.2 for a more detailed definition) as they encounter alternate perspectives (Cranton, 2016). A disorienting dilemma may result in adults critically reflecting on their unexamined assumptions that form their habits of mind and add to their frames of reference. Critical reflection potentially affects an individual's interpretations and perceptions of experiences, their approach to problem-solving and their planning for future action (Mezirow, 1991; 2000). Critical reflection, which at interview, Mezirow (2015) admits is central to TLT, may lead to perspective transformation (Illeris, 2014a; 2014c; Mezirow, 2009; 2012; Mezirow & Associates, 2000; Mezirow et al., 2009).

The phases that lead to a transformation of perspectives have been mapped by Mezirow (1991; 2000) (See Box 4.1) although he states that an individual will often follow a variation of these stages. Perspective transformation depends on action and the individual's reintegration into life, incorporating their new perspectives and frames of reference. People do not return to old perspectives in the event of transformation, but consistent forward movement through the phases toward transformation is rare (Mezirow, 2000). Stalling and backsliding at any phase may occur due to self-deception, particularly in the initial phases of transformation because this is when long and firmly held beliefs are challenged or where important relationships are threatened due to a need for action (Mezirow, 2000).

It is useful here to speak a little about transformation which,

refers to a movement through time of reformulating reified structures of meaning by reconstructing dominant narratives. The process may itself become a frame of reference, a dispositional orientation (Mezirow, 2012).

Kegan (2000) and Illeris (2014b) both question what transforms as a result of transformative learning. Illeris concludes that a transformation in perspectives is a shift in thinking and being in the world, and differs from the type of learning that relates to the acquisition of knowledge or skill (Illeris, 2014a). It is in the reforming and transforming of frames of reference that change and learning can occur and this is about the development of the identity; as Merriam and Bierema (2014) suggest learning is about the whole person. From his findings based on the question of what transforms, Illeris (2014b) proposes the following definition where:

the concept of transformative learning comprises all learning that implies a change in the identity of the learner (p. 40).

This definition reflects everyday language, incorporates the breadth of adult learning and acknowledges that it is the identity that transforms due to changes in the frames of reference. It is the definition adopted in this study.

Discourse and transformative learning

In TLT, discourse involves dialogue between participants and ‘critically reflective thinking leading to a best tentative judgment’ (Mezirow, 2009, p. 20) involving dialogue where beliefs, feelings and values are assessed (Mezirow, 2003). The ideal conditions for discourse are never entirely played out in practice but

...reflect democratic ideals such as self-respect, respect for others, acceptance of the common good, and willingness to be open and engage in diversity (Mezirow et al, 2009, p. 20).

The conditions for discourse ideally allow participants to engage freely and fully in communicating with others requiring personal security, health, and education. To participate fully in critical discourse and fully understand the meaning of our experience requires two adult learning capabilities: the capacity to engage in critical self-reflection and reflective judgment (Mezirow, 2003). Participants must be free of coercion and distorting self-perception and possess an openness to alternative viewpoints that incorporate empathy and concern for the way others think and feel; it is thinking about the unknown and what the other person is attempting to communicate, and in this,

[I]magination is central to understanding the unknown; it is the way we examine alternative interpretations of our experience by “trying on” another’s point of view’ (Mezirow 2012, p. 85).

This is the foundation upon which empathy is built and occurs through discourse. For discourse to occur participants require the ability to assess arguments with a level of objectivity, an understanding of context and knowledge of taken for granted assumptions including their own. There must be an opportunity to actively participate in the roles of discourse with

...a willingness to seek understanding, agreement, and a tentative best judgment as a test of validity until new perspectives, evidence or arguments are encountered and validated through discourse as yielding a better judgment (Mezirow, 2009, p. 20).

Habermas (1984; 1989) described this form of respectful communication as *subject to subject* dialogue and this was an area that influenced Mezirow's work.

Critical reflection on assumptions and transformative learning

Critical reflection is a central component of TLT and the process of meaning making by adults (Cranton, 2006; Mezirow, 1990b). It is also central to the question in this study; ECRNs: how and why do they stay? Mezirow suggests that

To make meaning means to make sense of an experience; we interpret it. When we subsequently use this interpretation to guide decision making or action, then making meaning becomes learning. We learn differently when we are learning to perform than when we are learning to understand what is being communicated to us. Reflection enables us to correct distortions in our beliefs and errors in problem-solving. Critical reflection involves a critique of the presuppositions on which our beliefs have been built (Mezirow, 1990b, p. 1).

Mezirow (1991) distinguished between content, process and premise reflection in his early writing and it is useful in developing and explaining the framework for this study.

Cranton (2016) provides a useful definition and distinction between the three types of reflection: content, process and premise. Content reflection examines the content or problem, where the learner asks 'what happened here?'. Process reflection looks at the strategies learners use for solving a problem, attempting to understand the process of solving a problem. Premise reflection is when the question itself is questioned asking 'why is this important to me?' moving below the surface to make conscious the unexamined assumptions that have led to the problem – it is an examination of the premise. Although all three types of reflection may lead to transformation, it is premise reflection that I am concerned with in this study, investigating if and how ECRNs were emancipated from the constraints of their unexamined assumptions through critical reflection on the premise of their disorienting dilemmas.

Critical reflection on assumptions is a central concept in the way adults learn to think for themselves rather than relying on the thoughts, concepts and values of others (Mezirow, 1998a; Mezirow, 2015). Mezirow differentiates reflection from critical reflection and points out that *reflection* is a 'turning back' (Mezirow, 1998a, p. 185) on experience, taking things into consideration or imagining alternatives, but it does not imply an assessment of that which is being reflected upon and is politically neutral (Kreber, 2012). Kreber proposes that *critical reflection* relates to reflective thinking such as that described by Dewey (1933) and reflective practice as explained by Schon (1987) but differs from this type of reflection due the foundations in critical theory and links to social action such as those espoused by Friere (2000) or Habermas (1971). From this perspective, critical reflection connects the thinking of the individual to the collective to make conscious the hegemonies that exist in society and influence ways of thinking about things. Critical

reflection is necessary for challenging ways of thinking and traditions and the premises that lead to hegemonies (Nussbaum, 1997).

Transformative Learning Theory in this study

TLT offers a way of thinking about and investigating how and why ECRNs remain working within the profession by investigating their disorienting dilemmas. As discussed, constructivism, humanism, and CST influenced the development of TLT. In this study I have used a unified approach to TLT, not valuing one approach above another but instead seeing the relationship between them; one cannot be in the world without it influencing an individual's frames of reference. Similarly, relationships between humans must impact on each other. To this end, it was essential to think about the research question, the participants and the framework that underscores this thesis. In this study, I acknowledged the following, and while divided into separate points here, they are nonetheless intricately linked and interdependent:

1. *The importance of context.* Nursing is a situated profession and nurses work in a vast variety of settings including but not limited to rural and remote, community-based, mental health care, palliative care hospices, hospitals, critical care areas such as intensive care and emergency departments, universities, schools, regulatory and professional organizations, detention centres, public and private institutions and the list goes on. Not only are there different types of work associated with each environment, there are also different ways of working and cultures within cultures, each with certain norms, values and beliefs. The context in which each participant worked may contribute to their

disorienting dilemmas and the way in which they were approached. Context also incorporates the environment outside the workplace.

Mezirow (1991) defines lifeworlds as

a "culturally transmitted and linguistically organized stock of interpretive patterns" or "perspectives." This daily universe of social activity that we take for granted, this pre-reflective lifeworld that provides the "context-forming horizon" of learning, is made up of a vast inventory of unquestioned assumptions and shared cultural convictions, including codes, norms, roles, social practices, psychological patterns of dealing with others, and individual skills. Communicated through language, it provides learners with a basis from which to begin negotiating common definitions of situations (p. 69).

ECRNs who are moving into new contexts, extend their lifeworld and interact with the lifeworlds of others, this is central to this study and the ECRNs frames of reference including the ways they make sense of their experience. While the stories told by the participants in this study may demonstrate individual transformation, it is intricately linked to their past and present experiences and to the profession in which the ECRNs have commenced, presenting contexts that can be transformed through the collective action of individuals and groups in shared and autonomous contexts.

2. *Acknowledging that humanness and nursing are relational and communicative.* Nurses work with others, often in stressful and frequently changing situations (Benner et al., 2010). To do this, nurses must interact and engage in listening and empathy, through discourse using a variety of mediums. TLT uses discourse as a primary method by which

transformation can occur by questioning previously unexamined assumptions and the testing of knowledge.

3. *Learning happens to the whole person and can occur anywhere* (Merriam, 2008; Mezirow, 2015). I acknowledge that learning is not confined to formal educational institutions. Merriam and Bierema (2014) suggest learning happens to the whole person and a change in perspective may occur as the result of what goes on in a person's head, heart, body and soul and is lifelong (Jarvis, 2006). The focus of this study concerning the ways of knowing, centres on perspective transformation described earlier. While I acknowledge that instrumental and communicative approaches to learning occur and that transformation can ensue at those levels; it is the transformations that occur within the ECRNs' frames of reference and the questioning of the premise that I sought to explore.

Conclusion

This chapter presented and explored the theoretical and philosophical underpinnings for this study. I have used an approach based on TLT which was first presented by Mezirow in 1991 based on his and others writing and research. An overview of the foundations of TLT is an essential element in contextualising the study and identifying the principles drawn from constructivism, humanism and CST.

In the next chapter, I will discuss the narrative approach used to collect the stories of ECRNs participating in this study to enable the investigation into how and why they remain working as nurses and how they make meaning from disorientation. Given the

ways of knowing in transformative learning, with a reliance on discourse and relationship, the centrality of critical reflection on assumptions and the focus on perspective transformation, a narrative approach was seen as a sound and reliable vehicle to use to search for meaning.

Chapter Five. Research Design

Introduction

In the previous chapter I discussed transformative learning theory (TLT), explaining how it provides the philosophical and theoretical principles that guide the study. In this chapter I will describe and defend the research design used. A qualitative methodology was utilised, employing a narrative approach. In the first part of the chapter I will focus on a critical discussion of the methodology and the justification for its choice including the applicability to the context. In the second part of this chapter I will detail the method, outlining the process for the collection and analysis of ECRNs stories including ethical considerations and approaches to ensuring trustworthiness of the research.

Background to the research.

It is not so much what happens to people but how they interpret and explain what happens to them that determines their actions, their hopes, their contentment and emotional well-being, and their performance (Mezirow, 1991, p. xiii).

As discussed in the previous chapter, TLT was used as the philosophical framework to provide direction and focus for this study. To briefly recap, TLT is an idealised theory of adult learning (Mezirow, 1981; 1991; 1992; 1994; 1997; Mezirow et al., 2009) developed in the latter part of the 20th century, acknowledging that adults learn in different ways to children. The process of transformation begins with a disorienting dilemma which occurs when unquestioned or unassimilated assumptions no longer serve to manage a situation. New ways of thinking and acting are necessary and develop through the transformation

of frames of reference; disorienting dilemmas act as a catalyst for learning and change (Mezirow, 1991). This study has investigated the disorienting dilemmas experienced by early career registered nurses (ECRN) and examines how and why they stay working in the profession.

Denzin and Lincoln (2011) state that qualitative research is a field of enquiry in its own right, cutting across disciplines, fields of study and subject matter. The breadth of its application means that qualitative research may signify different things depending on the reasons and the context in which a study occurs (Denzin & Lincoln, 2011) to reflect the range of experiences that might be encountered. The tensions between qualitative and quantitative research paradigms have existed for many years, often focussing on the application of terminology, for example, reliability and rigour. The reason the terminology and associated processes are not applied across paradigms is because qualitative and quantitative approaches to research are not the same (Golafshani, 2003). Qualitative research is contextually based requiring a design that is fit for purpose rather than that which seeks reproducible results. Rather than identify causal or generalised relationships, qualitative researchers seek to illuminate, understand and extrapolate to similar situations (Golafshani, 2003; Hoepfl, 1997) and is the reason a qualitative methodology was chosen for this study.

The flexibility and fluidity of qualitative research enables the capturing of experience, the exploration of the way people make meaning and allows access to otherwise unheard voices in society (Liamputtong, Anderson, & Bondas, 2016). Denzin and Lincoln (2011) offer a broad definition of qualitative research as 'a situated activity that locates the

observer in the world' (p. 3) using interpretative practices to transform the world and attempt to understand the meaning people attribute to the experiences they have. Polkinghorne (2005) states that the area of study should determine the paradigm of inquiry and Creswell (2009) suggests when there is little exploration into a phenomenon then it warrants a qualitative study as it is designed to explore the experiential life of people (Polkinghorne, 2005) and investigate the way they make meaning (Rossiter & Clarke, 2008). Merriam and Kim (2012) recommend consideration of two factors when selecting a methodology for an inquiry; first, the philosophical perspective to be employed and second, the question being investigated. The choice of methodology for this study was fit for purpose to allow the exploration of the research question ECRNs: how and why do they stay? Exploring their disorienting dilemmas. To do this, the methodology needed to support a constructivist perspective aligning with the assumptions of the philosophical framework, TLT, my own philosophy of learning and experience and one that would ensure participants and their stories were treated respectfully.

The first element in deciding upon a methodology is establishing a philosophical perspective and the beliefs about the world that support the study (Merriam & Kim, 2012). The philosophy of the research is drawn from multiple perspectives, both theoretical and personal. This study is constructed by me with assistance and advice from others. We all bring our own frames of reference including ideas, values, beliefs, knowledge, and skills. The philosophy encompasses abstract ideas that inform the choice of methodology drawn from theories that guide the way the study is interpreted (Creswell, 2013) but also the personal biography of the researcher that sits behind the

research (Denzin & Lincoln, 2011). My personal philosophy impacts on this study, and the reasons for the narrative preference, were discussed in Chapter Two. TLT and the way it guides this study were discussed in Chapter Four. Mezirow (1991) clarifies that constructivist assumptions are embedded within TLT and that attribution of meaning exists with the individual, while acknowledging that those personal meanings are acquired and validated through human interaction and communication. Broadly speaking this accepts that truth, of which there is no single version, exists with the person. It is their interpretation of experience that constructs reality, a construction influenced by their past experiences and the contexts in which they find themselves, including their relationships with others as they live in and interact with the world.

The second consideration when deciding on a research methodology, is the questions the researcher is attempting to answer (Merriam & Kim, 2012). This study sought to investigate ECRNs: how and why they stay in the profession by exploring how they made meaning of their experiences when faced with a disorienting dilemma. It was about hearing the participants stories (and in this study, story and narrative are used synonymously) and how they interpreted, made sense of and lived through their disorienting dilemmas. It was giving participants a voice.

Through this research, I aimed to 'expand the understanding of a phenomenon' (Spector-Mersel, 2010, p. 209) via exploration and interpretation of the individual's experience. A qualitative approach was deemed as the most appropriate to this study, acknowledging that 'Experience has a vertical depth [aiming to] capture the richness and fullness of an

experience’ (Polkinghorne, 2005, p. 138). In this study, the aim of the methodology used was,

to produce a coherent and illuminating description of and perspective on a situation that is based on and consistent with detailed study of the situation (Ward-Schofield, 1993, p. 202).

Narrative approaches to research

There is a remarkable parallel between transformative learning and storytelling. Transformative learning is about making meaning of experiences and revising perspectives when experiences are encountered that are discrepant with previous assumptions and beliefs. Story telling is a way of making meaning of experiences in all cultures and across all times (Kroth & Cranton, 2014, p. 25).

This study employs transformative learning as its theoretical lens which relies on critical reflection of self and assumptions and discourse to help make meaning of experience. Narrative and storytelling is a meaning making exercise (Bruner, 1990; Polkinghorne, 1988; Rossiter & Clarke, 2008) providing a sturdy and fit for purpose vehicle (Tyler & Swartz, 2012) by which to explore the questions posed in this study, *how and why ECRNs stay working in the profession*. Clark (2010) reminds us that ‘to be human is to tell stories’ (p. 3) and Rossiter and Clarke (2007; 2008) suggest that story is more than a recounting of events but a crafting of identities. Stories connect us to each other as nurses but also as humans (Douglas & Bourgeois, 2018) where a story about the past is also one about the present and the future (Brockmeier, 2000). Ricoeur (1983) refers to stories as re-descriptions of the world and Bruner (1991) asserts that narratives are a version of reality that can only achieve verisimilitude rather than empirical verification. Stories enable the

creation of new knowledge by the transformation of experiences (Carroll, 2010). Tyler and Swartz (2012) view storytelling as a relational exchange of experience that happens as a 'social process that can foster transformative learning' (p. 455). The research reported in this thesis used a narrative approach, listening and helping to form the stories of ECRNs experiences.

The following section explores the concept of narrative inquiry, elucidating on the approach adopted in this study and the rationale for its use.

Narrative Inquiry

Narrative inquiry, explores people's stories and is well suited to researching transformative learning as it allows people to convey personal experiences of transformation through story (Merriam & Kim, 2012; Tyler & Swartz, 2012). The use of the word narrative has entered the everyday discourse of society to explain and describe the way individuals, groups and organizations come to know about and make sense of experience (Spector-Mersel, 2010). The term narrative carries many meanings, is used in a variety of ways (Bruner, 1986; Esin, Fathiand, & Squire, 2013; Polkinghorne, 1988; Riessman, 2008) and is identified in many forms including the visual, written and spoken. Many authors do not differentiate between the terms narrative and story as is the case in this research study (for example, Douglas & Bourgeois, 2018; Polkinghorne, 1988; Riessman, 2008; Rossiter & Clarke, 2008).

In recent years there has been a turn to narrative, resulting in its use as a methodology in the human sciences (Clandinin, 2007; Clandinin & Connelly, 2000; Clark, 2010; Connelly

& Clandinin, 1990; Denzin & Lincoln, 2011; Riessman, 2008; Spector-Mersel, 2010). Clandinin (2007) identifies four major assumptions that signify the turn to narrative thinking and researching, including acknowledging the relational nature of the research; the use of words as data rather than numbers; a shift in focus from the generalisable to the specific and a widening acceptance of different ways of knowing. Bruner (1986) asserts that multiple realities are possible and describes two modes of thought or ways of knowing – scientific or paradigmatic (actual) and narrative (possible). According to Bruner, the scientific verifies and convinces by the appeal to empirical methods whereas the narrative convinces not of truth but verisimilitude. Bruner further explains that each is necessary in adding to and reflecting the complexity and diversity of knowing because each offers different but necessary ways of ordering experience and constructing reality. He warns that '[e]fforts to reduce one mode to the other or to ignore one at the expense of the other [will] inevitably fail to capture the rich diversity of thought' (Bruner, 1986, p. 11). This closely links to the levels of learning discussed in TLT where at the instrumental level, empirical methods may best serve to investigate an hypothesis, whereas at the communicative level, discourse or in Bruner's world, narrative, provides the mode by which understanding and meaning is sought.

Habermas, a German philosopher and Mezirow both highlight the significance of discourse and its relational nature. Habermas refers to subject to subject communication, where discourse occurs through dialogue between humans and is juxtaposed with the subject to object relationship. In a subject to object relationship the subject objectifies the other and in so doing depersonalises them and dialogue does not occur in a communicative way (Habermas, 1984; 1989). TLT also highlights the

importance of dialogue in making sense of experience (Mezirow, 1990a; 1990b; 1991; 2003; 2009; 2012). My aim in working with the participants in this study was to engage in subject to subject communication through dialogue, maintaining respect for them and their stories. Entering a respectful relationship with participants rather than an observational one (subject to object), accepts that participants are intimately bound to and informed by their context and the relationships, history and culture that construct the frames of reference that filter it. Those involved in the discourse including me as the researcher, bring to that relationship dynamic worldviews where growth and learning can occur (Clandinin, 2007).

Based on Dewey's work on the continuity, interaction and situation of narrative inquiry, Clandinin and Connelly (2000) offer the three-dimensional narrative inquiry space as a method to consider and explore narratives. Their framework was adopted in this study, used to guide participant interviews and form and analyse their stories. The three-dimensional narrative inquiry space encompassed the personal and social (interaction); the past, present and future (continuity) and; a place (situation) where

any particular inquiry is defined by this three-dimensional space: studies have temporal dimensions and address temporal matters: they focus on the personal and the social in a balance appropriate to the inquiry: and they occur in specific places or sequences of places. (Clandinin & Connelly, 2000, p. 50).

Working within this space highlights the relational dimensions of the inquiry (Clandinin, 2006) and provides a way of understanding and studying experience, where people are viewed as the 'embodiments of lived stories' (Bruner, 2004; Clandinin, 2007, p. 43) and

the stories are the focus of meaning (Spector-Mersel, 2010). Narrative enquiry is about capturing and analysing experience from the four directions within the three-dimensional inquiry space: *inward*, *outward*, *backward* and *forward* (Clandinin & Connelly, 2000). *Inward* refers to the internal conditions such as feelings, hopes, aesthetic reactions and moral dispositions. *Outward* signifies the environment or context. The *backward* and *forward* denotes temporality; the past, the present and the future. This approach was used to guide the interviewing of participants whilst seeking to investigate the historical, social and psychological filters through which they interpreted and understood their experience (Mezirow, 1991).

The process described acknowledges and relies upon a collaboration between researcher and participant (Clandinin & Connelly, 2000), recognising that narrative is not an objective reconstruction of life but rather a rendition of how life is perceived (Bruner, 2004; Oliver, 1998; Riessman, 2008; Webster & Mertova, 2007) remembering that narratives create experiences for their audiences (Mattingly, 1998). Narrative approaches to research draw on the constructivist paradigm for its ontology, conceiving a constructed but holistic narrative social reality that is fluid and multifaceted, connecting humans and collectives with their identity, with others and with culture (Spector-Mersel, 2010). Narrative also draws from constructivism for its epistemology in that we come to know the world and who we are through stories situated in the narrator's present (Spector-Mersel, 2010).

Riessman (2008) explains that there is no simple, clear definition of narrative, but suggests that

‘in everyday oral storytelling, a speaker connects events into a sequence that is consequential for later action and for the meanings that the speaker wants listeners to take away from the story’ (p. 3).

Along the same lines, Polkinghorne (1988) proposes that narrative in its most basic form links events to create a single episode which increases meaning and understanding of those events and the significance of particular occasions. Goodall (2008) points to the relational nature of meaning making through storytelling and narrative ways of knowing as they connect storyteller to listener or reader. Clark (2010) writes that storytelling has a social nature, where there is always a real or imagined audience even if it is ourselves, that helps to shape the narrative. Writing or telling a story changes not so much what we know but the way we think about what we know and how we know it (Goodall, 2008).

In telling a story, events evaluated as important and meaningful for an audience are chosen, organized and connected. Riessman (2008) speaks of Aristotle’s examination of Greek tragedy, where action is imitated and the dramatist creates a reproduction of events, experiences and emotions. The underlying constructive elements in these cases include the sequence and sense of temporality where there is a beginning, a middle and an end. The plot is where the organizing theme helps to highlight the individual events and ordering of incidents to construct the whole (Polkinghorne, 1988, p. 18) and constitutes what is referred to as the life blood of the narrative where plot is central. This study does not limit the definition of story to fictional tales but rather is interested in the story of lives and episodes within the lives (Polkinghorne, 1988) of the ECRNs. The research question provides the plot around which events are sequenced and developed and the ECRN stories are viewed as constructions; an interpretation or mirroring of

experience where the truth is expressed according to the individual at the time of telling and interpreted by those who read, listen or analyse them. The method used in this research study is based upon the methodological and philosophical underpinnings previously described. The following section will explicate the application of the narrative approach in this study.

Methods

This section details the process undertaken to collect and analyse the stories of ECRNs who participated in the study. ECRNs were encouraged and facilitated to tell the stories of disorienting dilemmas that had caused them to question their ability or desire to remain working as an RN. A narrative approach allowed access to professional craft and experiential knowledge (Clandinin & Connelly, 2000).

Ethical Considerations

Ethics approval to conduct this research was originally obtained from the University of Canberra, Committee for Ethics in Human Research (EC00108). Before any data collection commenced, my supervisor moved to the University of Wollongong (UoW) and I transferred my enrolment there. Ethical approval was subsequently granted from the Human Research Ethics Committee (HREC) at the University of Wollongong, New South Wales, Australia (Ethics number HE14/060) (refer to Appendix 2).

All participants were provided with a participant information sheet written in plain English (See Appendix 3) outlining the research study, the purpose, potential risks and

the benefits of the study. Contact details for the research supervisors and the Research Services Office were included.

De-identification of each participant was undertaken, not to dehumanize but rather to protect participants and to make them feel safe to tell and share their stories (Hill & Burrows, 2017). All collected data remained confidential and deidentified. Initially coding numbers were applied to the transcripts (for example P1). During story construction, pseudonyms were applied (Polit & Beck, 2012) and linked to the coding numbers rather than the participants' personal details to maintain their privacy. Names are a part of everyday culture and of enormous importance for those who receive them (Deluzain, 1996). In line with Habermas' (1984, 1989) concept of subject to subject dialogue, the application of pseudonyms acknowledged that the story was created by, about and for humans, linking it to the reader and others in the world. For example, a story explaining the feelings or challenges described by Cathy was more connected to the human experience than explaining the thoughts and feelings of P1.

Participation was voluntary and none of the researchers (supervisors or myself) had any supervisory relationships with participants.

Riessman (2008) suggests that the 'specific wording of a question is less important than the interviewer's emotional attentiveness and engagement and the degree of reciprocity in the conversation' (p. 24) stressing the need to listen attentively not only to hear the telling of stories but as a mark of respect. Gubrium and Holstein (1998) recommend that 'one needs conversational "space" if one is to tell an extended story; teller and listener

must work together to create the conversational environment in which a story might emerge' (p. 176).

All interviews were conducted face to face in a mutually agreed, private location away from the participant's workplace, to create a safe space where they could share their personal experiences about being a registered nurse and without feeling concerned that their information might be overheard by their workplace supervisors or colleagues. As the person conducting the interviews and co-creator of the stories, I aimed to demonstrate respect for each participant who was gifting their experience, their stories and their time. Respect was demonstrated through active listening, remaining mindful that each participant's time was valuable and being transparent and honest about the use of information (Polit & Beck, 2012).

The welfare of the participant was always placed before the research by assuring participants that they could discontinue the interview at any time and decline to answer questions. As an RN, manager and clinical supervisor, I am skilled at interviewing and assessing individuals in distress and referring them for professional assistance if required. During interviews, participants often spoke of situations that were upsetting, made them angry or embarrassed, however no one requested their interview stop or requested referral for professional assistance.

Background and setting

The Narrative Research Process

Like narrative itself there are many ways to undertake the collection and analysis of information using a narrative approach to research (Riessman, 2008). In this study, transformative learning theory forms the conceptual and guiding framework as discussed in Chapter Four. The approach in this study applies constructivist assumptions, recognising that the interview and story is a co-construction between participant and researcher and considers the broader social construction of the story within interpersonal, social and cultural relations (Esin et al., 2013). Esin et al. (2013) suggest this approach

is not really interested in internal states that can be separated off from the narratives themselves. It is interested in the states produced socially by the narratives; the narratives themselves are, in such accounts, social phenomena (p. 204).

Figure 5.3, illustrates the iterative narrative research process used in this study. Each phase represents an increasing depth of analysis as I became more familiar with the participants' experiences by visiting and revisiting the transcripts and recordings. Inhabiting the three-dimensional narrative enquiry space, I moved backward and forward between phases and in and out of the stories. The evolving and deepening analysis sought to identify the strands and threads woven through each story and those that moved beyond and across individual stories, contributing to the collective narrative within the context of the thesis. With a greater view, themes were identified and woven into the hermeneutic of nursing. Finally, a parable was constructed to move beyond the

hermeneutic of nursing, releasing the ideas into the broader fabric of society, where nursing exists, interacts and merges with the interstitial spaces of other hermeneutic worlds. The parable sought not to answer questions but create an experience for and in the reader; the ghostly audience (Riessman, 2008) encouraging them to ask their own questions as the stories, ideas and lifeworlds collide and intertwine. The following sections will extrapolate on the research process employed in this study and illustrated in Figure 5.1.

Figure 5.1: Narrative research process used in this study

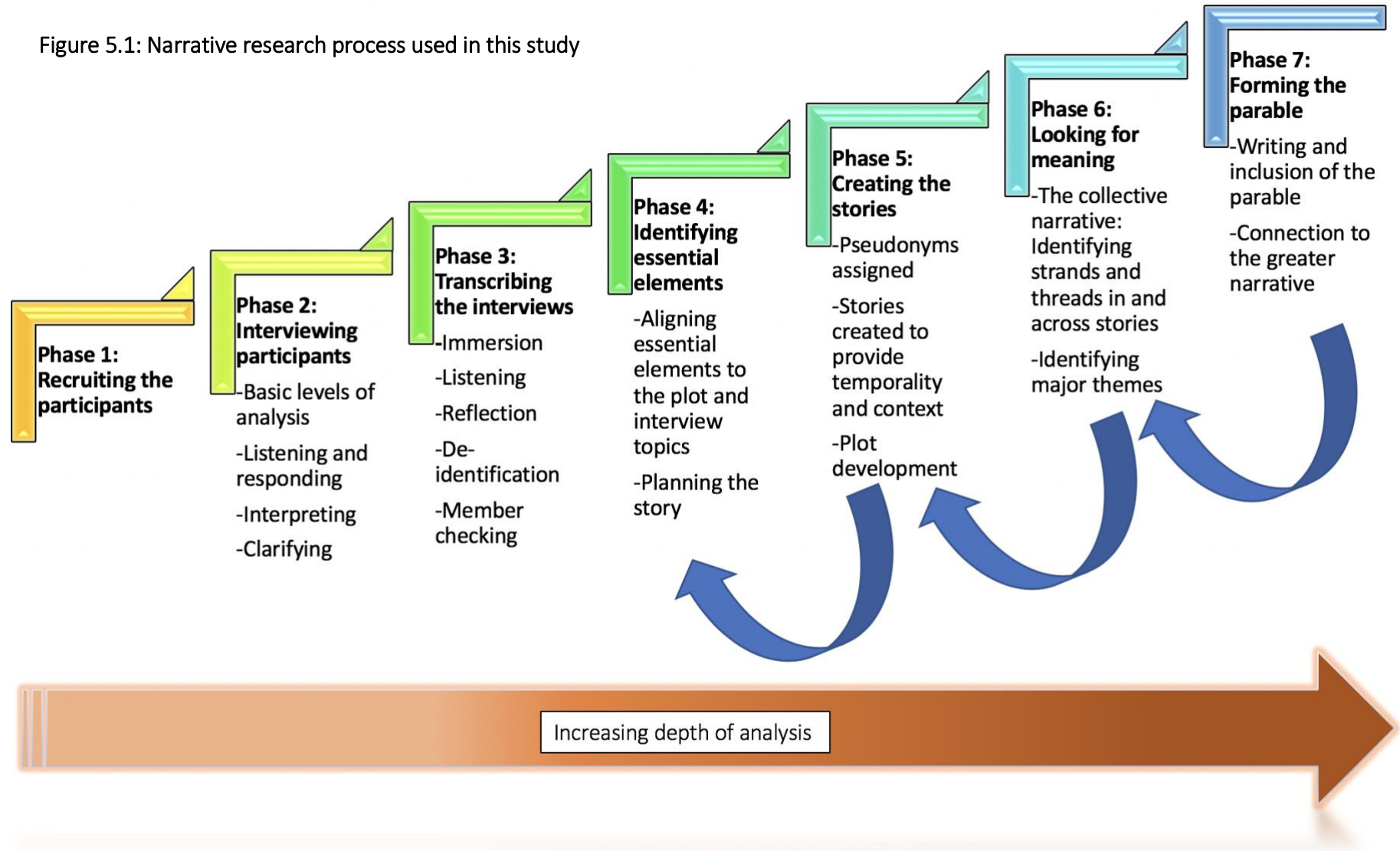




Figure 5.2: Process of extraction and analysis of information

Data Collection

Phase 1: Recruitment

According to Australian Government figures collected as a part of the workforce survey, in 2015 there were 256 034 RNs employed as RNs in Australia (Australian Government, 2016; AIHW, 2016). The majority worked in hospital settings, with approximately 600 full time equivalent (FTE) nurses and midwives per 100 000 population. 277 667 (90 percent) of nurses (RNs and Enrolled Nurses (EN)) and midwives were working in clinical roles, defined as anyone spending the majority of their time working in the area of clinical practice (AIHW, 2016). Based on the figures available, the participation criteria sought to attract participants from the following areas: acute care (which encompasses critical care, emergency care, medical, surgical and perioperative nursing), aged care, mental health and community nursing. These clinical areas have been identified as the ones that employ a significant percentage of the Australian nursing workforce and a major employer of nurses at all levels. Speaking with ECRNs from these areas provided stories from the contexts in which they are most likely to be employed and therefore areas that would benefit from information to support ECRNs who work there. It also allowed me to listen to and incorporate voices across different contexts of nursing.

Inclusion Criteria

Inclusion criteria was developed and informed by the research question and workforce data (AIHW, 2016; HWA, 2012; 2013) (See Box 5.1). Areas identified as large employers of RNs across Australia (listed above) were purposively targeted. Box 5.1 identifies the inclusion criteria.

Participant inclusion criteria

To be eligible to participate in this study the applicants will be:

- ◆ an RN registered with AHPRA for at least one (1) year and not more than five (5) years (inclusive)
- ◆ an RN who had completed a Bachelor of Nursing (BN) or equivalent (for example educated overseas but registered as an RN in Australia through AHPRA).
- ◆ an RN (at the time of recruitment) working in one of the following clinical areas of nursing in a full, part time or casual capacity at the time of recruitment:
 - ◇ Acute care nursing (including critical care, emergency care, medical, surgical and perioperative nursing);
 - ◇ Aged care nursing including palliative care nursing;
 - ◇ Mental health nursing or
 - ◇ Community nursing.
- ◆ employed as an RN in Australia.
- ◆ willing to be involved in a voice recorded interview
- ◆ willing to sign a consent form agreeing to be a part of the study

Box 5.1: Participant inclusion criteria

Recruitment strategies

Multiple ethics approved strategies were used to invite ECRNs to participate in the study. Strategies included advertising on a professional organization's social media site and distribution of card invitations (See Diagram 5.1). A webpage was created through the University of Wollongong and accessed through their research site. The site (accessed at <https://smah.uow.edu.au/nursing/research/UOW173428.html>) outlined the study (See diagram 5.3) and provided the ethics approval number and an invitation to participate. This was a useful site as it validated me as the researcher and gave ready access to information about the study.


Purposive sampling was used to identify participants for this study. In purposive sampling each participant is chosen because they represent a particular population and 'will provide unique and rich information of value to the study' (Lee-Jen Wu, Hui-Man, & Hao-Hsien, 2014, p.111). The study sought to understand and gain insight into how and why ECRNs stay working in the profession by exploring their disorienting dilemmas and so it was this group of RNs who was targeted, providing all criteria, outlined in Box 5.1 were met.

Snowballing techniques, where participants emerge through a process of reference from one person to another (Ritchie, 2001; Streeton, Cooke, & Campbell, 2004) were used to identify participants and proved to be the most successful recruitment strategy.

Those interested in participating in the study were asked to contact me using one of the methods listed on the recruitment material (telephone, email address and text number). Once contact was made, an email of introduction was sent and included, an invitation to participate (see Appendix 1) which provided an overview of the study; information regarding ethics; expectations of participants and; a link to the website (see Figure 5.3). If still interested in participating, and to avoid coercion, ECRNs were asked to contact me and signal their acceptance to move forward and participate. One follow-up, reminder email was sent.

Those who agreed to participate were posted an information pack containing a participant information sheet (see Appendix 3) that provided information about the study, ethical clearance from the University of Wollongong, a consent form (see Appendix

4) and contact numbers for me and my supervisors. The pack also contained a postcard (see Figure 5.4 and 5.5) and a stamped addressed envelope so participants could return their consent form and completed postcard. Participants were also told that they could bring the postcard and signed consent form to the interview if they chose. The postcard will be discussed shortly.



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Figure 5.3: Screen shot of the study website and invitation card

This study investigates how and why nurses remain working within the profession.

To be a part of this study you are asked to:

1. Complete this postcard and
2. Participate in a face to face interview.

To complete this postcard, you are asked to think about an event that has affected your decision to keep working as a nurse. This event may be a clinical or life experience. You are asked to summarise this event on the back of the postcard using the following headings

Situation: What happened?

Action: How did you react/respond?

Outcome: How did this affect your decision to remain working as a nurse?

Please return your postcard in the envelope provided

A wide-angle landscape photograph showing a calm body of water in the foreground, which perfectly reflects the sky and the mountains. The mountains in the background are rugged, with some peaks covered in snow or light-colored rock. The sky is a deep blue, filled with soft, white cumulus clouds. The overall mood is peaceful and majestic.

Jane Douglas, PhD Candidate, University of Wollongong.
jadb679@uowmail.edu.au. 0418662913

My Story.....

Situation: What happened?

Action: How did you react / respond?

Outcome: How did it affect your decision to remain working as a nurse?

Thank you for your time. Please return your postcard in the envelope provided. Jane Douglas.

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Originally 17 participants from around Australia were recruited using the approaches described above. Four participants were unable to continue; in three cases a mutual time and place for interview could not be found and in the third case the ECRN moved overseas before an interview could be conducted. In the end 13 ECRNs from a variety of workplace settings met the criteria and agreed to participate in the study. A brief narrative sketch introducing each of the ECRN participants was constructed using their individual stories and can be accessed in Appendix 5.

Postcards and permission

‘Despite their brevity... postcard stories are readily identifiable as conventional short stories, featuring plots, settings, and characters’ (Vipond, Hunt, Jewett, & Reither, 1990, p. 117). Postcards serve ‘both as a personal memento of the experience and as a means of extending it to other potential tourists as recipients’ (Markwick, 2001, p. 417). Whilst Markwick (2001) refers to postcards as a way of relaying the stories of tourists, this is not dissimilar to the use of the postcards in this study.

Participants were asked to complete a postcard prior to their interview, to summarise a significant event(s) (disorienting dilemma/s) and post it to me or bring it to the interview; at this point, I was essentially the tourist in their world. Postcards were a reflective tool, designed to assist participants to isolate and reflect upon a significant event(s). The terms *significant event* and *challenge* were used instead of disorienting dilemmas as it is more readily recognised as part of everyday conversation. The postcards used a ‘Situation, Action, Outcome’ (SAO) framework drawn from Flanagan’s (1954) Critical Incident Technique (CIT). This framework provided a succinct way to guide the participants reflections and thoughts. The completed postcards provided a point of shared reference

between participant and myself and a springboard from which the interviews could proceed.

Many participants stated that they had thought deeply about what they would write on the postcard, demonstrating that it had the desired effect of helping them to channel their thoughts and reflect upon their experiences. The experiences recorded on the postcards were discussed during interviews along with other experiences that emerged.

Phase 2: Individual interviews

The analysis in this study aimed to make sense of the experiences of the participants, considering their context. Riessman (2008) suggests, analysis begins during the interview which heightened the importance that I conduct the interviews. Interviews were semi structured using a set of guiding topics (or prompts) developed from the research question and the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000). Guiding topics (see Box 5.2) aimed to assist participants describe their experiences and move them from the pre-temporal to the temporal (Polkinghorne, 1995). In this study, the plot focused on the significant events and challenges or disorienting dilemmas experienced by ECRNs and how they processed them. The outcome was how and why ECRNs made the decision to remain working in the profession.

The three-dimensional narrative inquiry space (Clandinin & Connelly, 2000) was used to investigate the disorienting dilemmas and challenges faced by ECRNs; looking inward to examine internal conditions such as feelings, motivation, thoughts, reactions, values and beliefs; looking outward to investigate the context in which ECRNs lived, worked and

socialised and; looking backwards and forwards to discuss the ECRNs past and present, including their reasons for deciding to become an RN and their pre-registration education and the impact on the future (Clandinin & Connelly, 2000).

Guiding Topics for Interviews

An introduction to the study and participant background.

An explanation about how the interview would progress and the reasons, implications and responsibilities for the study was reiterated. Participants were asked to give their verbal consent which was recorded.

Demographic information

Discussion investigated the participants past and the present situation. Information about pre-registration nursing studies, their age and when they had entered nursing was reviewed. The context in which the participant was working at the time of the interview and past employment and education was discussed. A brief narrative picture of each ECRN participant was constructed and is included as Appendix 5.

Why enter nursing?

Participants reasons and motivations for deciding to become an RN were investigated, including the people or experiences that had influenced that decision.

Expectations

The expectations and motivations held by participants about being an RN before commencing study, while studying to become an RN and upon beginning work as an RN were explored as was the relationship between these expectations and their experience. Their expectations and experiences of their nursing education were also discussed.

Challenges

Participants were asked about the challenges they had faced since commencing work as an RN. This included reflection and dialogue about overall and specific challenges.

The term significant event and challenge were used instead of and synonymously with disorienting dilemma as it was thought these terms were in common usage. The

situation, action, outcome (Flanagan, 1954) approach was used to frame situations. The three-dimensional narrative inquiry space (Clandinin & Connelly, 2000) guided the discussion and delved deeper into the experience. Participants were asked to talk about what happened; the actions they and others took in response to the situation; their thoughts and feelings at the time; the outcome of the situation, including the type and level of support they looked for and/or were offered and; how they felt about the situation.

The interviews explored how the situation was disorienting for the ECRN, how it affected their view of nursing and if their view of nursing changed as a result of those experiences, the effect the situation had on their decision to remain working in the profession and how and why ECRNs stay working in the profession because of or despite what had happened.

Support

Participants were asked to reflect on and discuss the way they had faced the situation/s, the type of support they had accessed, been offered and received and to critically reflect on self and the assumptions that underpinned their responses.

Conclusion

Participants were asked if there were any other issues, thoughts or comments they would like to add. Participants were thanked for their participation and informed of the process regarding member checking.

Box 5.2: Guiding Topics for Interviews

The choice of guiding topics for the interviews was discussed individually with each supervisor and piloted with a colleague prior to meeting with participants. As a result of the pilot, the experiences of the participants pre-registration education were included in the guiding topics. The necessity to become very familiar with the guiding topics became clear to allow interviews to flow without interruption and allow me to remain focussed on the participant and their story. I did not want to miss what a participant was saying

as the interview was the time to pick up on cues, employ clarifying and extempore questioning and make comments to demonstrate engagement, after all, the interpretive process begins during the conversation (Riessman, 2008). Active listening and clarifying questions provided an opportunity to check that my interpretation aligned with the participant's descriptions. This was especially important for constructing the stories and reflecting the voices of participants.

Phase 3: Transcription

I transcribed all interview recordings verbatim, forming the raw text. Transcription presents an opportunity for immersion into the data and yet another level of analysis (Riessman, 2008). As Riessman (2008) suggests a transcript 'straddles a border between speech and writing' (p. 29) and can only ever be a representation of the face to face interview. Transcripts were de-identified during this phase to maintain participants' privacy (Australian National Data Service, ND; Polit & Beck, 2012). As a part of the process of de-identification participants were initially allocated a numerical code for example P1 and later pseudonyms were given for reasons described earlier.

Once each interview had been transcribed, I listened to the recordings again while reading through each transcript checking for accuracy, making notes on significant issues and corrections where necessary. This reading and listening allowed further analysis, moving more deeply into the ECRNs' stories, presenting a further opportunity to identify and understand the emerging ideas and essential elements.

Phase 4: Identifying essential elements

Essential elements were drawn from the transcripts to help form and tell the story, provide context, define the plot and outcomes and give sequence to the experiences described by participants. It is the essential elements in formation that help to tell the story and provide the richness and thickness of the text. This may be described as narrative smoothing (Spence, 1986). Clandinin and Connelly (2000) advise this occurs in narrative all the time but warn that the researcher needs to be wakeful to this process, so it is not used as a method to produce clean, unconditional plots. The aim of smoothing in this thesis was the construction of ECRN stories by combining and ordering elements that smooth the plot into a 'temporally organized whole' (Polkinghorne, 1995, p. 5).

The essential elements template (see Box 5.3) was developed by refining the interview guiding topics (see Box 5.2) and were used to form each of the participants' stories. Polkinghorne's adaption of Dollard's (1935) criteria for judging a life history, written 'for all those who study events related to human beings action above the level of the mechanistic biological' (Dollard, 1935, p. 5) were considered when deciding on the essential elements. Of note is the insistence on considering the participant in situ, including investigation of their history, culture, expectations and the retention of their humanness which resonates strongly with both narrative inquiry and TLT. Polkinghorne suggests

Although the configuration process cannot be accomplished by following an algorithmic recipe, certain steps are commonly used in the production of storied narratives. The story is a reconstruction of a series of events and actions that produced a particular outcome (1995, p. 18)

Essential Elements used to form stories
<p>The context.</p> <p>Why nursing?</p> <p>Expectations of being a nurse?</p> <p>Challenges since becoming a nurse (disorienting dilemmas)?</p> <p>How they stay? Approaching and managing challenges.</p> <p>Why they stay?</p>

Box 5.3. Essential Elements used to form stories

Although analysis continued throughout and beyond data collection, extraction of the essential elements from each transcript did not commence until all transcription was complete. The template was used by me to begin the formation of the story, extracting the essential elements from the transcript and placing it into the template to provide sequence to the story and fullness to the experiences. In doing this each ECRN's experiences were drawn together to provide a detailed picture.

Phase 5: Creating the story

Stories were constructed using narrative analysis based on Polkinghorne's (1983; 1988; 1995; 2005) work. The construction of the story was guided by the research question, drawing from the description of experiences in each transcript and formed using the essential elements template (See Box 5.3). The authenticity of the story is based on the ability to explain experience in a coherent and situated way (Connelly & Clandinin, 1990). The power of the story is in the presentation of an individual in a unique situation, dealing with issues in a personal manner (Polkinghorne, 2006). Each story was written as a standalone text allowing it to speak for itself. The use of the essential elements template allowed a systematic approach to the development of each story while maintaining its

uniqueness with a focus on the personal meaning of experiences (Polkinghorne, 2007) to the ECRN.

Transcripts were analysed and stories written as stand-alone texts. I focussed on writing one story at a time in order to immerse myself in that story and retain momentum. Like the interviews and transcripts, this phase involved moving forwards, backwards and in and out of the transcripts to identify and extract the essential elements. It was during this phase that pseudonyms were applied to each story to ensure the retention of humanness but maintain a safe narrative space for participants.

Phase 6: Looking for meaning

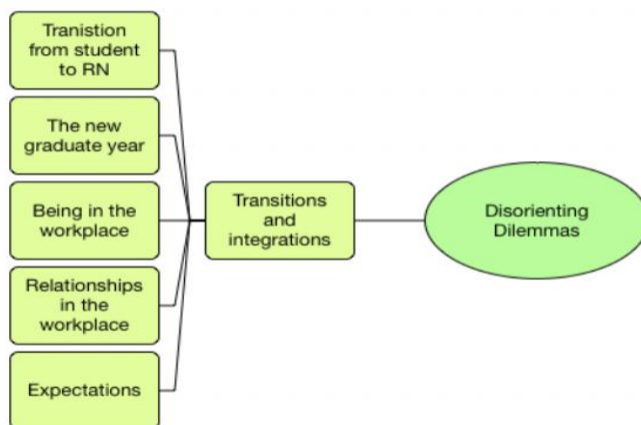
The stories constructed from participants' transcripts 'signify narratives that combine a succession of incidents into a unified episode' (Polkinghorne, 1995, p. 7). Once constructed, stories were viewed as texts and the basis of analysis as the strands and threads running through each text was explored.

Exploration of the stories was conducted in several ways. Interviews and story creation involved analysis at increasing levels of depth. Completed stories were uploaded to NVivo for Mac 11.4.3 and initial coding was undertaken within each story to develop a sense of the strands and threads running in and through each. NVivo was also used to organize threads for the collective narrative (Diagram 5.6 shows an example of this type of organization in NVivo). The NVivo program was used primarily as a repository to assist in the organization, coordination and classification of threads but ultimately the analysis is always the role of the researcher (Bazeley, 2013). Immersion and revisiting of ECRNs'

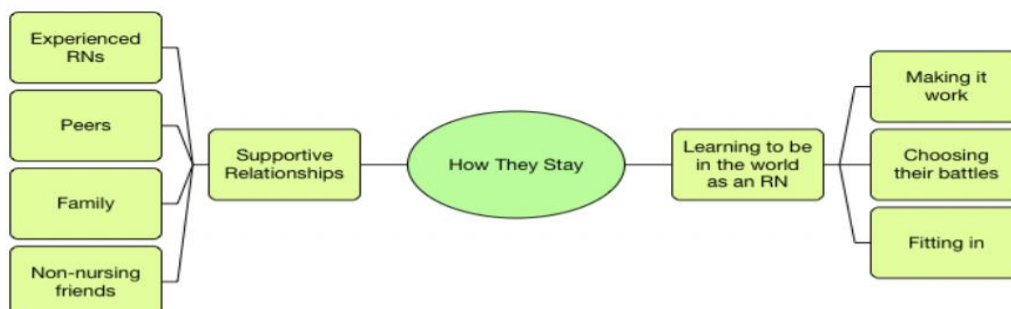
stories were the processes used to identify strands and threads, initially within each story and then across stories identifying and grouping the similarities and identifying overarching themes. Threads and strands are discussed in Chapter Six and the themes are examined in relation to the literature and the greater narrative of nursing in Chapter Seven.

Mind maps created using NVivo for Mac 11.4.3

Disorienting Dilemmas: Threads



How They Stay: Threads



Why They Stay: Threads

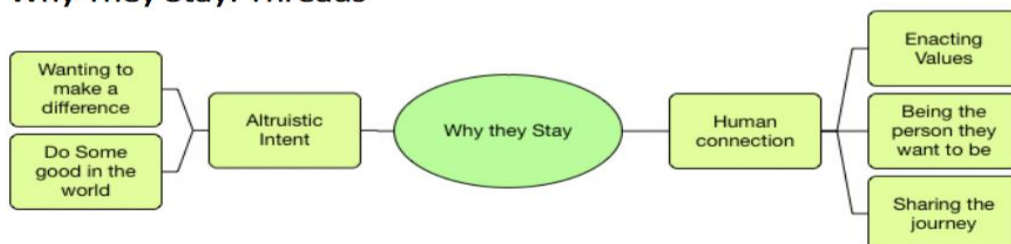


Figure 5.6. Example of how NVivo was used in this study

Phase 7: Formation of the parable

A parable is ‘... more than a sign, it is a bearer of the reality to which it refers. The hearer not only learns about that reality, he [sic] participates in it. He is invaded by it...’ (Wilder, 1971, p. 84). Parables do not tell people what to do but rather subvert teaching, causing the reader to question their responses to situations and look beyond the accepted norms (Thiselton, 1992). During this phase of the study and following, I constructed a parable based on the identified themes, not to generalise but rather to raise questions in the reader, transforming and transcending the collective narrative to the greater narrative and moving to emancipatory ways of knowing (Habermas, 1989) based on a shared and connected humanity rather than a particular hermeneutic.

Recommendations

Based on the findings and the evidence, recommendations are made. The recommendations relate to the identification of the ways that ECRNs make meaning of their experiences and the strategies used to help move through disorienting dilemmas in their early careers and remain working as RNs; how and why they stay. The themes, drawn from the findings have informed the development of multilevel, multifocal recommendations in this thesis and consider ways forward.

Credibility and trustworthiness

According to Creswell and Miller (2000) qualitative researchers should demonstrate the credibility of their research. Several processes have been applied in this study to reflect the underlying constructivist assumptions and ensure credibility and trustworthiness. The methods used to ensure credibility and trustworthiness include, member checking, peer review, the iterative nature of the narrative construction and situating myself in the

research landscape, acknowledging the co-construction of interview transcripts and thus the stories. These are described below in relation to this study.

Member checking

Member checking was conducted during interviews and on each of the ECRN interview transcripts. Member checking provides participants with the opportunity to engage with interview data following in-depth semi-structured interviews (Birt, Scott, Carvers, Campbell & Walter, 2016). This was a time consuming but essential part of the research process and occurred through a number of methods. Probing and clarifying questions were used during the interviews to check my interpretation with the ECRNs (Polit & Beck, 2012). Following transcription, participants were posted a printed copy of their interview transcript and asked to check for accuracy (Polit & Beck, 2012) and inform me if there was information they would prefer be excluded (Birt et al., 2016). One participant requested removal of reference to her previous academic studies as she thought the esoteric nature of those studies might lead others to identify her. This information was deleted from the transcript. The transcript was sent again for checking, at which point she gave her approval for the transcript to be used. Once participants notified me that they were satisfied the transcript was accurate and de-identified the document could be used for story construction and further analysis.

Peer review

A peer reviewer acts as someone one who critically reflects with the researcher about their research (Creswell, 2013; Lincoln & Guber, 1985). Peer review was an ongoing process throughout the entire study. Regular discussion with individual supervisors by telephone, face to face, skype and by email were methods used to obtain ongoing and

in-depth feedback on the processes employed in this study. Supervisors responded to plans, analysis and written work at all stages of the study and records of feedback kept. During discussions, challenging questions and critical discourse such as those pertaining to possible bias in the work, helped to ensure participants' voices were central to the findings and their privacy protected. Updates on the study were presented at annual research schools conducted by the University of Wollongong and at a national conference in Australia and an international conference in Singapore. Such opportunities provided another forum for academics and fellow HDR students to ask questions, discuss the work, provide feedback and help me to reflect critically on assumptions.

Positioning self in the research: standing in the landscape.

To demonstrate credibility and trustworthiness it was essential to position myself as the researcher, within the landscape (Caine, Estefan, & Clandinin, 2013; Clandinin, 2006, 2007; Denzin & Lincoln, 2011; Rossiter & Clarke, 2007; Spector-Mersel, 2010; Birt et al., 2016). Chapter Two explained how I came to the research question and the constructivist assumptions that underpin the study. Being conscious of the motivations for conducting research, together with peer review helped me to remain mindful of issues that may arise. Through the experience of working as a nurse I had some understanding of the places where nurses work and the jargon used. The impact that my experiences could have on the interpretation of participant stories was at the fore of my consciousness during interviews, analysis and interpretation. Following each interview, I reflected critically with self and supervisors to bring into consciousness my values and beliefs that potentially could overlie and direct the responses of participants. Listening to the recorded interviews, reading the verbatim transcripts, internal dialogue, individual

discussions with supervisors and critical feedback on my work provided the vehicles to identify and investigate these types of practices and evaluate impacts on the study.

Conclusion

This chapter has elucidated and provided justification for the use of a narrative approach in this study. I have acknowledged the relational and interpretive nature of the methodology which is well suited to the research question and the philosophical framework of TLT. I have provided a description and justification for the narrative research process which was an iterative one. The process for ensuring credibility and trustworthiness was described in detail. The following chapter will present a discussion about the strands and threads that emerged from the ECRNs stories in relation to the research question. In order to address the research question, the strands and threads will be discussed in three sections; the disorienting dilemmas and challenges; how and; why they stay.

Chapter Six. Strands and threads: the collective narrative

Introduction

Fabric is constructed by weaving together many threads. Threads are formed by twisting together strands of material for example cotton, wool or silk (See Figure 6.1)

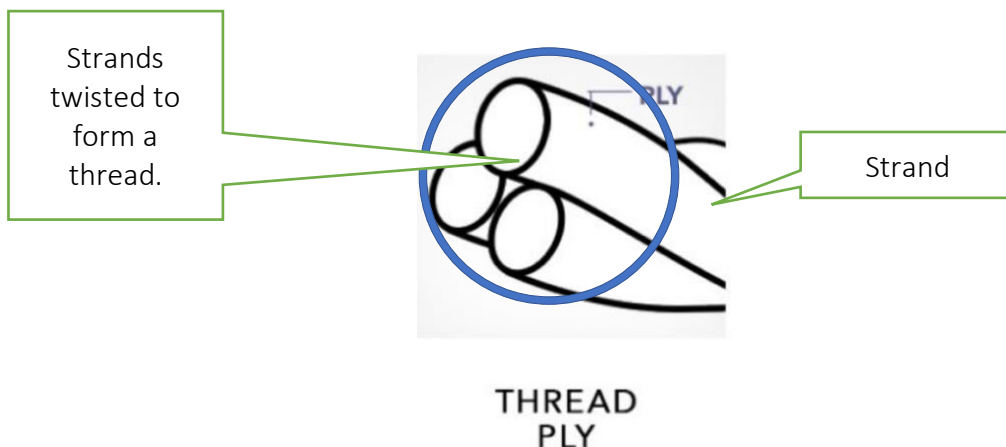


Figure 6.1: The formation of threads (Sewingpartsonline.com, ND)

The characteristics of a thread are created by the ply (number of strands), the direction of the twist and the finishes used. The twisting of the strands may form a thread that has a sheen, is waxy in appearance or one that has a much more rustic texture. It is in the weaving together of threads that fabric is created, but the fabric is influenced by the characteristics of the thread. There is a co-dependence between the threads and the way they are woven; both integral to the look of the cloth; the drape, the texture, the colour and the design. Fabric cannot exist without these two elements, they are essential. Rather than deconstructing and losing the context, fabric can be scrutinised using magnification to examine the threads and the weave. In this way threads can be examined closely without destroying the fabric, viewing it from different angles and in

different lights. How do the threads create a fabric, with its particular texture, colour and design? What is it that makes it unique, causes it to drape in a certain way or reflect light to create shadows?

Each of the ECRN stories in this study is like an individual piece of cloth formed by the twisting of strands to form threads and woven together to create the fabric of their experience. As I listened to, transcribed, read and re-read the ECRNs' stories, the uniqueness of each was apparent, but through this immersive process, I could see threads emerging, running through individual stories but also across them. In this way, the stories were woven together forming the more substantial fabric. As this happened themes also became apparent, and a picture of the thesis came into view; the collective and greater narratives where the lifeworld's merged but retained their uniqueness. The 'fabric' of the thesis was forming.

In this study, I have used a narrative approach and a TLT lens. As such, it is grounded in constructivism and therefore is interpretive. The discussion is not based on discovering *a* truth but rather the plausibility of the interpretation (Polkinghorne, 2007). Others may read the same ECRN stories but with a different perspective, finding and examining different threads or identifying other themes. That is the nature of the story; even when turned into text it continues to evolve, merging with the stories of those who listen to or read them, interpreting others' stories through different lenses and experiences (Clark, 2010; Kroth & Cranton, 2014). This chapter examines the strands and threads running in and through the 13 ECRN stories. To provide context while maintaining privacy, a brief

narrative sketch of each of the ECRN participants was constructed using the individual stories and can be accessed in Appendix 5.

Three broad areas, based on the research question are considered in identifying and explaining the strands and threads including; the disorienting dilemmas and challenges; how they stay and; why they stay (see Table 6.1). In this chapter I look inward to the ECRN stories to discuss the identified strands and threads. In Chapter Seven I will look outward to examine the way the threads form the fabric and when woven together form the themes, creating the fabric of the study.

Element	Strands	Threads
Disorienting Dilemmas and challenges	<ul style="list-style-type: none"> • The transition from student to RN • The new graduate year • Being in the workplace • Workplace relationships • Responsibilities and expectations 	Transitions and integrations Relationships in the workplace
How they stay?	<ul style="list-style-type: none"> • Relationships with <ul style="list-style-type: none"> ○ experienced RNs ○ peers ○ family ○ non-nursing friends 	Supportive relationships
	<ul style="list-style-type: none"> • Making it work for me • Fitting in • Learning to be me • Choosing their battles 	Learning to be in the world as an RN
Why they stay?	<ul style="list-style-type: none"> • Practical reasons • Making connections • Wanting to make a difference and to help people • Do some good • Enacting values 	Making a difference
	Sharing the journey of the patients / clients	Being with others

Table 6.1: Strands and threads across ECRN stories

Disorienting Dilemmas and challenges

To consider how and why ECRNs remain within the profession, I investigated the disorienting dilemmas faced by a group of 13 ECRNs. Although discussed in detail in Chapter Five it is useful to recap briefly on what constitutes a disorienting dilemma (see figure 6.2).

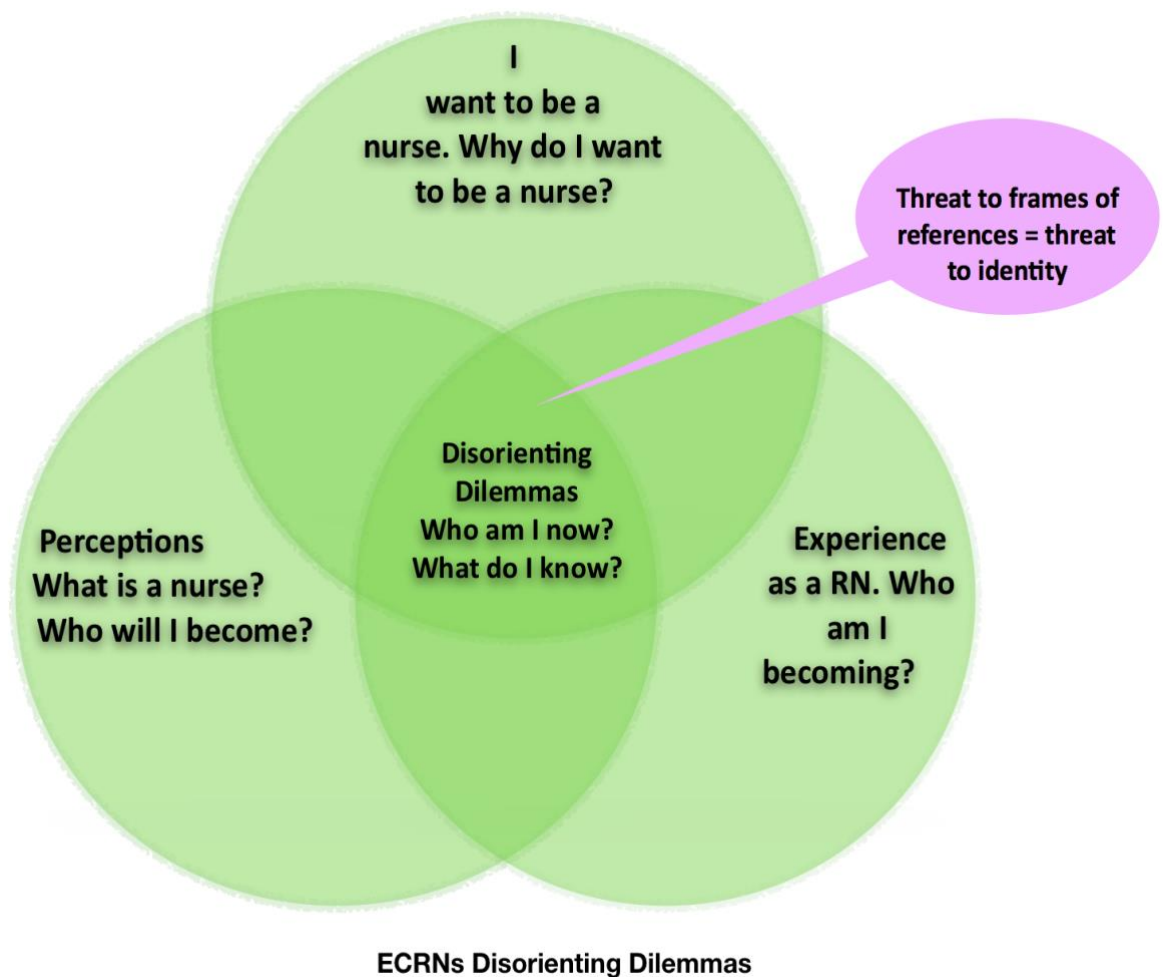


Figure 6.2: ECRNs disorienting dilemmas

Transformative learning begins with a disorienting dilemma which may lead to critical reflection on assumptions and perspective transformation upon which the individual acts (Bourjolly, Sands, Finley, & Pernell-Arnold, 2015; Illeris, 2014a; Mezirow, 1991). Disorienting dilemmas illuminate and challenge previously invisible and unquestioned assumptions that frame the way we know ourselves and the contexts in which we exist (Taylor & Elias, 2012). Disorienting dilemmas serve as a catalyst for entering a process of learning and change; they are a call to action, to critically reflect and examine the assumptions that underpin a person's frames of reference (Mezirow, 1991; 1998a; 2012). They form part of the journey toward authentic ways of being (Mezirow, 1991) where authenticity is 'characterised by agency, choice, reflection and rationality' (Tennant, 2012, p. 35).

As discussed in Chapter Four, Illeris (2014a) concludes that what transforms in transformative learning is the identity, impacting the whole person, not just one element. The challenges and disorienting dilemmas described by the ECRNs in this study sparked a threat to their developing identity by bringing into question their frames of reference which encompass their habits of mind and points of view (See Box 4.2 for definitions used in TLT). This is the story of ECRNs becoming and learning to be themselves. It is the journey toward authenticity and emancipation from unrealistic expectations that have the potential to govern thoughts and action. The following section will describe the threads, that emerged within and across ECRNs stories examining the strands that form those thread.

Thread: Transitions and integrations

In Australia, RNs register with the NMBA after completing a program of study approved by the NMBA (2016b; 2016e). All RN, pre-registration programs in Australia must be at Bachelors level or above and include a combination of theoretical and practical experiences incorporating at least 800 hours of workplace experience in a variety of settings (ANMAC, 2012). All ECRNs in this study completed a Bachelor of Nursing degree in Australia, and all those programs were three years in duration (or the part-time equivalent). During their study, students cannot register as an RN, meaning their first day of work is the first time they will have practised as an RN. The ECRNs in this study highlighted the significant challenge associated with this transition. The following strands contribute to this thread and centre around transitioning to the role of RN.

Strand: The transition from student to RN

Participants spoke of the overnight transition from student to RN, as daunting. The full impact of being in the practice world and accepting the responsibility of being an RN was unexpected and unimagined by the ECRNs in this study. ECRNs were propelled into situations where their identity and reasons for entering the profession were questioned, by themselves and by others and ECRNs found themselves in situations where prior approaches to change were no longer valid because the assumptions underpinning their frames of reference about what they expected of the role were found to be inaccurate.

Jon described the move from student to RN as a quantum leap and Chris spoke of the link between those roles as worlds apart. Upon commencing work as an RN, Sarah felt unaware of and unprepared for the complexity of the role. Claudia and Sarah felt that

despite being new graduates, they were still RNs with the same responsibilities as someone with 20 years of experience and perceived that patients would have the same expectations of them, as of any RN. Cathy and Polly described the 'massive responsibility' they felt when starting work, knowing that they were accountable for the lives of many people and suggesting that an RN must always be aware of their actions because a mistake can be catastrophic for the patient and their career. Helena said once registered and working she became acutely aware of the responsibility associated with being an RN and while her theoretical knowledge was excellent, she did not have the technical experience to practise confidently and apply that knowledge. She said she was aware, of the implications and consequences of making a mistake as an RN and felt an obligation to seek assistance and support. Each ECRN spoke of their sense of accountability for the patients in their care, especially concerning medication administration. Cathy and Claudia both shared stories of medication errors, although no one was injured, they both described their feelings of devastation and a sense of impending doom.

Advocating for those in contact with and utilising the health system was seen by this group of ECRNs as an essential responsibility of being an RN and was for several, a fundamental reason for entering the profession. Patients, clients and families, colleagues, new nurses and nursing students were all groups mentioned as those that may require their advocacy. For participants, who had been working for one to three years, knowing how to act as advocates in their role as RNs was a challenge. This challenge was intensified because they were working in a system and in cultures that were unfamiliar and frequently in a state of flux. It was also evident from their stories, that the ECRNs needed to weigh up the risk of speaking out and the negative

consequences that might result. Liz, Sarah, Susan and Claudia all stressed that they did not want to be the nurse who complained or made a fuss, especially as new RNs in the workplace.

After confronting his manager regarding negative comments she had made about patients on the ward, Jon concluded that he needed to choose his battles wisely and make considered decisions by looking at situations more objectively and strategically. His attempts as an RN and a student to question the way RNs in the workplace referred to patients or behaved toward colleagues resulted in his tacit exclusion from discussions, educational opportunities, team leading roles and patient information. This had emotional and financial implications. He also came to believe that increasing his credibility through further education would bring with it an increased capacity to advocate for others, especially clients and patients.

For ECRNs who had been working three and five years, the challenges of the ever-changing health care system remained, and there was almost a sense of resignation associated with this. As this group of ECRNs accepted increasing levels of responsibility, taking on team leader and Clinical Nurse Specialist (CNS) roles, advocacy for clients was central, but the need to care for colleagues grew in importance. Han and Jan had been working as RNs for three and five years respectively, and viewed their team leader role as a crucial one. The ability to lead the team effectively meant advocating for and supporting staff to fulfil their roles, and in this way they were also advocating for clients and the care those clients received. Han, a Clinical Nurse Specialist (CNS) and team leader, found staff shortages led to poor skill mix on the ward where she worked. She explained that poor skill mix presented difficulties for the experienced mental health

nurses, who were employed as permanent staff members as they tended to be allocated heavy and demanding workloads consistently. This allocation however was a necessity due to the increasing numbers of casual staff who held no specialist mental health education, being allocated to work in the area. Han found these staff were often ill equipped to take on the more challenging clients and expecting them to do so would threaten the safety of all staff members and the client. Han was also aware that permanent staff were at increased risk of burnout due to these allocations.

Jan observed the ward where she worked ran more smoothly when the staff felt valued and supported by the team leader. Advocating for staff was one way of demonstrating their value and supporting them, and as team leader, Jan attempted to do this. Working in the Intensive Care Unit, Chris felt a keen sense of responsibility to advocate for the clients in her care and for their families to protect their dignity and their relationships, acting as a conduit between medical staff and the patient and family. She also saw her advocacy extending to new staff and act as a role model, mentor and by just being friendly and helping others to navigate a health system she continued to find difficult. Chris' advocacy extended beyond her paid employment, working with an external organization, who advocated for nursing students and lobbied for positive workplace learning environments. Chris explained that at work she felt she was nobody but outside and through this external unpaid work she felt she could advocate and make a difference.

Strand: The New Graduate Year

In Australia, New Graduate (NG) Programs or Transition to Practice (TPP) Programs are organized and run locally by Area Health Services / Local Health Districts or individual facilities to provide ECRNs with a supported transition to the workplace. These are

neither standardised nor regulated, and in Australia, they are not compulsory; an ECRN does not have to complete a new graduate year in order to work as an RN. In this thesis the terms NG Programs and TPP are used interchangeably.

Following the completion of their pre-registration nurse education, all ECRNs in this study were accepted into and commenced a rotational, 12-month, new graduate program somewhere in Australia. In all cases, the selection was based on merit, judged through the ECRNs written application and in some cases included a formal interview. Han commenced a new graduate year but chose not complete it, due to pregnancy. She said she could have returned to finish the program following the birth of her child but decided to move into a speciality, completing a government supported, graduate program in mental health.

TPP completed by the ECRNs were developed by the facility or the area health service offering the programs but there were similar elements in all the programs discussed by the ECRNs. All TPP involved rotations through three to four different clinical and community areas and in some cases, different facilities. ECRNs completed organizational orientation and in some cases, supernumerary days were rostered to allow time to orient to the workplace (between one and two days) and in some workplaces, structured study days were scheduled throughout the year and organized by the facility. During the programs, ECRNs worked and were paid as RNs with workload allocations. Chris said she felt compelled to enter a program because by the end of her degree she did not feel competent to work as a nurse largely because of the comments made by RNs during

workplace experiences as a student and Claudia was advised that without a new graduate program and hospital experience, she may not find another job.

In this study, regardless of how long they had worked as an RN and without prompting, all participants spoke of their NG year as significant and challenging, both professionally and personally. Claudia spoke of a huge learning curve during the most significant year of her life, while Han found the work physically hard especially while pregnant and Jon talked of how unprepared he was for the behaviours from other nurses in the workplace. Liz suggested that her new graduate year had not been great and the level and consistency of support was less than she had imagined. The ECRNs in this study had experienced varied and mixed approaches to learning and support during their new graduate programs and which differed between and within facilitates.

Manley, Sanders, Cardiff, and Webster (2011) suggest that workplaces are made up of many cultures which exist at the grassroots level and when these cultures combined create an organizational one.

The rotational nature of the new graduate programs was problematic for Chris as it meant orientating to the culture of nursing generally when commencing work but then adjusting to the personality-driven sub-cultures existing in each area. Not all agreed with this and several ECRNs expressed the opinion that the opportunity to compare different areas helped them to move forward, as they realised not every area was the same; some more welcoming and helpful than others. Sarah found the clinical rotations beneficial as she could compare areas, and it offered the chance to experience and witness different

approaches to nursing and leadership. Helena, Claudia and Jon were grateful to move to different areas after challenging experiences in one of their clinical rotations.

The new graduate experiences described by participants were often distressing and disturbing for them, the significance highlighted by the fact that they spoke about that period up to four years on. Their discussions demonstrate the import of the new graduate year, stressing its impact on the developing identities of ECRNs and correlates with findings in other studies (Fernet, Trépanier, Demers, & Austin, 2017; Flinkman & Salanterä, 2015; Mills et al., 2016; Price, 2016). As participants spoke of the challenges at this time, they were often visibly upset, embarrassed or angry. While telling their stories, participants sometimes became teary, as in Chris's description of her treatment by the team leader in ICU when reporting a deteriorating patient. Claudia spoke of how difficult it was to retell the story of a drug error, blushing and explaining how she still felt embarrassed and ashamed by her mistake. Similarly, Samuel said he was still embarrassed when retelling the story of a patient who falsely accused him of having sex with her. Liz, Susan, Helena and Cathy, exhibited anger toward the handling of certain situations by other RNs or supervisors. The recounting of their stories still produced physical manifestations up to four years later and was a clear demonstration of the power of storytelling, where the 'telling and listening to life stories can have potent emotional effects' (Farrant, 2014, p. 463) but also the long-lasting effects of such experiences.

Strand: Being in the workplace

Reference to working in, navigating and managing the culture of nursing featured in the stories of ECRNs and was a thick and persistent strand. Drennan (1992, p. 3) suggests culture relates to 'how things are done around here' and Stein-Parbury (2014) defines

culture as a group of people who share a worldview that determines how they live, communicate and see the world. Culture is learned through the social interactions that occur within the group and is often taken for granted. Manley, Sanders, Cardiff, and Webster (2011) suggests that the notion of culture is complex and lacking in definitional consensus and Mezirow suggests it is imperative to name our reality, so it is made conscious and divorced from that which is taken for granted and

...thus it becomes crucial that the individual learn to negotiate meanings, purposes, and values critically, reflectively, and rationally instead of passively accepting the social realities defined by others (Mezirow, 1991, p. 3).

Manley et al. (2011) note the increasing reference to organizational culture in healthcare settings, arguing that the culture experienced by users at the interface of care must be acknowledged and acted upon if high-level reforms are to be implemented and sustained.

When they spoke of *culture*, participants generally referred to the specific context of their workplace not the overarching profession of nursing. In their discussions, they highlighted the way personalities, attitudes and behaviours of individuals and groups working in those contexts impacted on the ways of working in the area. Individuals and groups were spoken of as part of the culture, encompassing nursing staff (RNs and ENs), assistants in nursing, managers, supervisors and educators.

Annabel and Helena spoke of how as ECRNs they needed to manage the culture of nursing and the associated expectations of others and themselves. Liz talked about a

culture in nursing where many RNs did not seem to care anymore and how, as a new RN, enthusiastic about her new role, this was confusing and disheartening. Cathy, Susan and Sarah all spoke of RNs that continued to have difficulty accepting university educated nurses, describing examples where their nursing qualifications were denigrated, thus devaluing their experiences and identity.

Claudia found the approach to learning was area dependent, for example she found very different approaches in the intensive care unit (ICU) compared to the rotation in the medical ward. Coming to terms with the culture of nursing was a challenge for Chris because of experiences during workplace experiences undertaken as part of her pre-registration education. These experiences led Chris to feel she did not and would not know enough to work as a nurse when she completed her degree. Claudia described the nursing culture as one where to be accepted, she had to prove herself, which often meant completing another RNs work, as well as her own. Jon said that he was not prepared for the culture of nursing when he commenced work as an RN, witnessing new graduates crying in hallways and belittled during shift handovers. The similarity that emerged across stories was that navigating the culture of nursing for ECRNs was chiefly about navigating the relationships of those with whom they worked.

Participants spoke of being viewed with suspicion by colleagues and having to prove themselves in their new role, almost like 'an initiation'. Annabel said that colleagues viewed her with suspicion during and after her short secondment to the pain service in the hospital where she was working. Jon spoke of a situation of exclusion from the care of patients and where patient safety was placed at risk when the long-time employed,

assistant in nursing (AIN) with whom he was working, refused to share patient findings. When Jon raised this issue with his manager, he was told 'that is her', ultimately reinforcing and supporting the AINs behaviour.

Student Nurses

Worthy of discussion is the experience of participants as students, as this contributes to the formation of the ECRN frames of reference, their perceptions of self and their developing identities and was mentioned often by the ECRNs. Levett-Jones and Lathlean's (2008) study followed nursing students and their definition of belongingness and states it is,

a deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group. The experience of belongingness may evolve passively in response to the actions of the group to which one aspires to belong and actively through the actions initiated by the individual (Levett-Jones & Lathlean, 2008, p. 104).

According to their stories, the need to belong is also applicable to the ECRN experience. Lacking a sense of belongingness has been associated with deleterious emotional, psychological, physical and behavioural consequences and a diminished sense of self-esteem (Ashktorab, Hasanvand, Seyedfatemi, Salmani, & Hosseini, 2017; Borrott, Day, Sedgwick, & Levett-Jones, 2016; Hershcovis, Ogunfowora, Reich, & Christie, 2017; Levett-Jones & Lathlean, 2008; Mohamed, Newton, & McKenna, 2014). There is also a link between belongingness and learning, which suggests that when students do not feel they belong in an area during workplace experiences, their energy goes into managing

relationships rather than learning (Levett-Jones & Lathlean, 2008). The experiences described by the ECRNs in this study suggests that managing relationships should be seen as central to the learning experience not apart from it.

To register as an RN in Australia and fulfil the requirements of pre-registration programs of study, all students must complete 800 hours of workplace experience which is supervised, supernumerary, nursing practice (ANMAC, 2012). During workplace experiences, students may work with numerous RN preceptors who liaise with academic staff regarding student progression.

Participants spoke of negative comments from many RNs toward them during their workplace experiences, fostering feelings that they were not considered team members and presenting as a hindrance to the RNs with whom they were allocated to work. By the time Chris commenced work as an RN, she said she had come to believe she was a burden in the workplace. This awareness helped to construct and reinforce poor perceptions about the value of her experience, knowledge and skills. As students and ECRNs, participants felt their knowledge and experience was not valued or taken into consideration by those in the workplace. As a student, Susan looked on as the RN allocated as her preceptor, simulated beating her head against a brick wall when told she was to work with a student on that shift and then in Susan's hearing, made negative comments to colleagues about having to work with the student. At the end of the shift, Susan approached the unit manager and suggested that perhaps she could work with someone else the following day as the RN was unhappy about working with her. She said that by the time she arrived for the next shift, the interaction with the manager was known by most staff on the ward and resulted in her spending the many weeks of the

placement, known as the student who 'rats' on their preceptor. Jon described a similar situation of isolation when as a student undertaking a mental health placement and wanting to assist, offered to accompany a patient to the designated smoking area. The patient had requested to go for a cigarette on several occasions and over several hours. Jon's offer was rejected by the RN who proceeded to make disparaging comments about the patients in the facility and tell Jon that he had no idea about nursing. Following this incident, Jon was excluded from discussions and learning experiences. Cathy, Susan and Sarah were shocked when RNs complained to them about university 'trained' nurses and as students they became scapegoats for RNs dissatisfaction with the University model of nurse education. During her final workplace experience before graduation, one RN told Cathy that given their limited clinical experience it was no wonder new graduates did not know what they were doing, reinforcing Cathy's feelings that student experiences were not useful and ECRNs not competent despite their education and meeting the standards for practice expected by the NMBA.

The expectations of others in the workplace and the approaches used to impose those expectations were significant factors leading to disorienting dilemmas for this group of ECRNs. Upon commencing in their new role as RNs, all participants were acutely aware of their lack of experience as registered nurses. It seemed there was an expectation by some RNs and managers that completion of pre-registration qualifications should result in newly registered nurses who could enter any new context and apply their knowledge, despite never having worked as an RN before.

ECRNs stories described experiences of humiliation by educators or RNs in response to mistakes or when found to have gaps in their knowledge. When Claudia made a medication error (or a near miss), she was acutely aware of the severity and the consequences. During a formal meeting to discuss the error, her manager and educator raised a series of other issues about Claudia's performance. Claudia said she was unaware of these despite her frequent requests for feedback on her performance; the additional issues had not been raised before the meeting. As part of her probation and in response to the incident, Claudia was required to undertake remedial education on medication management which included being quizzed at four am on her very first round of night duty, about medications that were randomly selected from old medication charts. When Claudia told the educator, she had never administered those medications and would need to look them up, she was told that she should 'just' know about them.

Helena identified and admitted the gaps in her knowledge and technical skills which she attributed to a lack of experience working as an RN in acute and critical care environments. Up until her placement in the ICU (her second rotation) she had only ever worked as an RN in the mental health unit which required different skills and attributes. Helena's defence was disputed by supervisors who suggested that others had moved from mental health to acute areas and had managed. Helena felt unable to ask questions of colleagues as she believed this would be viewed as a weakness and reinforce her perception that colleagues thought she was an 'idiot'. When she became overwhelmed by her situation as a new graduate in ICU; her first acute care placement, she started to cry and was told by the supervisor to take a deep breath and act like a 'big girl'.

Chris was reduced to tears after commencing employment as an RN in the ICU. She had spent some time in the neurosurgical ward developing her skills in conducting neurovascular observations and she said this was one area of assessment she felt confident to perform. When she spoke with the team leader about her assessment of a patient with a deteriorating neurological status, she said she was 'ripped to pieces' by that RN regarding her method for the assessment and then left in the middle of the ward crying, with the assessment information and thus Chris' previous experience disregarded. The stories told by the ECRNs are filled with such experiences and seem indicative of an approach to working based on creating fear and administering humiliation rather than acknowledging the ECRN as an adult, lifelong learner (Cranton, 1992; Knowles, 1973) novice practitioner (Benner, 2001; Berry, Gillespie, Gates, & Schafer, 2012) but a person with previous experience.

Strand: Workplace Relationships

Relationships with managers and colleagues in the workplace was a significant strand in participants' stories. There were many relationships described that led to a diminished sense of agency, impacting not just their work life, but their whole life. A lack of transparency; poor or no communication from managers or colleagues; the inability by others to accept and support diverse ways of working; exclusion and being treated as objects by managers and colleagues led to disorientation and the ECRNs feelings of not being listened to or valued as an RN and therefore not as a human. Cathy, for example, was consistently rostered on days she had requested not to work as she could not find childcare for her three preschool-aged children. Liz was consistently rostered for too many shifts or for days she had requested not to work to allow her to attend pre-arranged and essential appointments and Susan could not book a holiday because she could not

gain approval for leave, despite placing requests, months in advance of the dates requested. When ECRNs spoke of these experiences, they were not expecting special treatment but rather criticised the lack of engagement and dialogue from managers resulting in the ECRNs feeling left out of decision-making processes about their lives. Health suffers when people have low decision-making authority, and this is linked to management styles in the workplace (Wilkinson & Marmot, 2003) and Tuckett, Winters-Chang, Bogossian, and Wood (2015) link a lack of managerial and organizational support with nurses' decisions to leave the profession. The challenges that led to disorienting dilemmas were those that were unexpected. It was the relationships with colleagues, managers and organizations that led to stories of angst and where participants felt a lack of professional agency which in turn impacted the ECRNs whole lives.

ECRNs described situations where they were isolated, excluded, or shut down or where they felt tested, or in positions where they felt the need to prove themselves or were judged negatively for a lack of knowledge or experience or criticised because the type of education they had completed did not align with other RNs experiences or judgements. There were situations where ECRNs lacked experience but also lacked the support of more experienced RNs to assist them as was the case for Liz when she witnessed her first cardiac arrest and was left with three other new graduates to manage the situation until the emergency team arrived, despite calls for additional assistance.

The term 'skill mix' was mentioned on more than one occasion by participants and describes the mix of grades, posts or occupations in an organization (Buchan & Dal Poz, 2002). In an age of nursing shortages skill mix is often the force driving the model of

nursing care adopted in a clinical area (Duffield, Roche, Diers, Catling-Paull, & Blay, 2010) taking into consideration the ‘... unique knowledge and skills that individual health care providers bring to their role’ (McGillis-Hall & Buch, 2009, p. 5). In Australia, RNs are expected to speak out about injustices, hazards and where the safety of patients or other staff is placed at risk (ICN, 2012; NMBA, 2016c; 2018b) but this is not always easy to do due to the power relationships that exist, particularly between ECRNs and more senior nursing staff. This was the case for Cathy who was hoping for study support or where the processes to deal with a situation such as sexual harassment do not work to protect the person speaking out, as occurred for Polly, who was advised by her mentor and more experienced nurses not to report the behaviour because the system didn’t work. Participants in this study provided numerous examples of the negative results of speaking out about perceived injustices against colleagues and patients; owning up to mistakes or a lack in knowledge or skill; issues with other staff members’ unsafe behaviours and poor attitudes toward patients. The ECRNs in this study had not expected peer, supervisory and managerial relationships to be difficult and the source of such angst, which is interesting given that many spoke of negative workplace relationships as students but perhaps this is related to their sense that they were not included in the nursing or healthcare team during their pre-registration education and workplace experiences. Participants lacked strategies to respond in these situations, lacking agency and where they were made to feel underqualified, their experience and knowledge devalued, and their reporting of results disregarded. Such behaviour has been associated with poor health outcomes for recipients and increased expressions in intention to leave (Vogelpohl, Rice, Edwards, & Bork, 2013).

Paternalistic attitudes and feeling unheard or undervalued, rendered ECRNs voiceless in a foreign and often daunting environment as they attempted to meet the perceived expectations of many, adding to the expectations they placed upon themselves. Cathy spoke of her dilemma in attempting to organize childcare for her three small children and negotiate rosters with her partner, also a shift worker. She had discussed with her manager how difficult it was for her to work Saturdays and while she understood that having every Saturday off was unreasonable, so too was being rostered for eight Saturdays in a row. Despite attempts to explain the difficulty of the situation with her manager, there seemed little attempt to empathise. Cathy recalled one occasion, having spent hours finding childcare that would allow her to work the rostered shift, signalling to her manager her distress at being rostered on the same shift the following week and facing the same dilemma. Cathy's manager suggested that she had been able to make it work last week and why couldn't she 'just' do that again? Suggesting a lack of regard for Cathy's situation.

Liz had good insight into the limitations imposed by a chronic health condition. Despite officially dropping her working hours 12 months previous, her roster continued to reflect a full-time workload and up to eight consecutive shifts, which played havoc with her health. Liz was forced to approach her manager each month to let her know the roster was incorrect which made her feel uncomfortable. Despite requesting in advance, two specific days off every second roster for necessary medical appointments, Liz continued to be scheduled to work on those days. This rostering meant having to ask colleagues to swap those shifts with her and resulted in her feeling indebted and duty bound whenever they requested a shift swap. With one week's notice, Cathy was moved to the nursing

pool rather than to an expected permanent position in her area of speciality nursing. This news was especially disappointing because of the implications for the scholarship she had received to complete an honours program investigating issues in the area of speciality in which she had been working. The lack of discussion and consultation about her career was discouraging, and she felt that it demonstrated little respect for her as a person. Making decisions about people's lives with little concern for their opinions or needs, removes the agency humans require to feel in control of situations (Wilkinson & Marmot, 2003). As an RN, Cathy suggested that she was expected to listen to patients' stories, to assess and understand their needs, but thought that those supervising her did not model that behaviour with staff.

In her fifth year of practice and working as an RN in rehabilitation, Jan spoke about the lack of acceptance by her managers of diverse leadership styles in her workplace. The style of leadership modelled and promoted was a transactional one, and discouraged collaboration or shared decision making. Jan attempted to treat all in the workplace with respect by valuing and supporting them in their work (Manley, 2004) using a non-confrontational approach and this she said was judged by her supervisors to demonstrate weakness. Jan found she was able to evaluate the difference in leadership styles through observation and reflection on the improved mood of staff on the ward during her shifts as the team leader. In Jan's story, it was not so much about the difference in styles she found problematic but rather the inability of her managers to support and value a diversity of leadership. Applying a person-centred approach to leading teams, as was Jan's' approach, demonstrates a transformative or transformational approach to leadership (Manley et al., 2011). Supporting different methods of leadership requires

supervisors to accept that things may not always work to plan and requires leaders to facilitate growth instead of attribute blame (Manley et al., 2011) and in this way transformational leaders motivate others to do more (Soloman & FitzGerald, 2008). Jan felt unable to go to her supervisors to discuss leadership issues and concluded that it was something she needed to sort out on her own. Organizations and management must be aware of the types of workforce issues facing those in the profession (Buchan et al., 2018; Duffield et al., 2011; OECD, 2017) and strategies that help to retain and develop strategic thinkers as a way of developing RNs who can lead and manage change in the future (Buchan et al., 2018) because styles of management can affect job satisfaction and retention of RNs in the workplace (Alingh, van Wijngaarden, vande Voorde, Paauwe, & Huijsman, 2018; Duffield, Roche, Catling-Paull, & Blay, 2010).

The disorienting dilemmas described by ECRNs in this study revolved around relationships with colleagues, supervisors and managers in their workplaces. They reflected that issues such as this were not included in their pre-registration education and thus not brought to consciousness and perhaps not imagined. Stories revealed that as students ECRNs did not feel that they were members of the healthcare team, often actively excluded from the team perhaps adding to the difficulty of understanding the relationships that exist in the workplace with no reference point to connect to. As West and Lyubovnikova (2013) suggest, the formation of a healthcare team involves more than the application of a label.

The question of lifelong learning and responsibility is important here. In Australia, expectations that RNs will continue their learning throughout their career is embedded in the Registered Nurse standards for practice at standard 3.3 (NMBA, 2016c) which are

used to judge fitness to register and work as an RN in Australia. The experiences of ECRNs in this study, raises the questions about where responsibility for lifelong learning lies and what it involves? The adequacy of pre-registration nursing programs and their ability to meet the demands of the industry is one question, the ability of industry in meeting the learning needs of the ECRN is another. Does support for learning in the workplace aim to assist ECRNs develop and integrate the RN role into their identity; in other words, is it emancipatory learning? One of the first steps in any learning environment is to understand the needs of the learner. There is a human inclination to take the theories, positions and ideas of nursing and translate them into 'dogma and prescriptive orthodoxy' (Bevis & Watson, 1989, p. 3). Over time these solidify into the assumptions that become accepted as the 'truth' about what nursing is and how specific practices close creativity. At the same time, there is a need to accept that nursing and nurse education is more than the acquisition of technical skills and knowledge, but is about the whole person and their identity as shown in the stories of the ECRNs in this study. Just as the identity is not compartmentalised, neither can the integration of the RN role be confined to pre-registration education; learning and development are lifelong and not restricted to formal education.

Strand: Responsibilities and expectations

The expectations ECRNs placed upon themselves, together with perceived expectations from colleagues, patients, managers, organizations and the profession were often disorienting. Liz and Sarah felt that patients expected the same level of skill and knowledge from them as someone who had been nursing for 20 years. Samuel spoke of the profession's expectation that new nurses would be change agents, although admitted this may have been a self-imposed expectation but concluding that either way, it

produced a feeling of heaviness. Annabel felt the implicit expectations of others and herself were impossible to meet, hindered her ability to work in her new role and caused her to consider leaving the profession. She described a disorienting dilemma when as the team leader for the shift she broke down unable to stop crying under the expectation to perform, combined with her perception that there was a lack of collegial support. Helena perceived the staff in ICU did not like her because she did not meet their expectations of what an ICU nurse should be able to do. For Jan there was a lack of managerial and organizational support concerning leadership positions and an expectation she would be able to do it but an unwillingness to support a diversity of approaches. Expectations from others were often covert, placing ECRNs in new environments, where negotiating situations also meant attempting to guess the expectations of others.

Terms such as, 'sink or swim', 'work ready' (Baldwin, Bentley, Langtree, & Mills, 2014) and 'hit the ground running' are terms used by the media, in universities, workplaces and by clinicians and managers, often without qualification or consistency as to their meaning. Baldwin et al. (2014) suggest that novice nurses need to be educated to be 'work ready' and Walker and Campbell (2013) state that employers expect nursing graduates to possess generic skills that are beyond the competencies specified by the discipline, implying a lack of consistency about the way work readiness is defined and applied by employers when engaging ECRNs. The abruptness of the transition from student to RN may not occur to those that work with and employ ECRNs. The belief that ECRNs needed to 'hit the ground running' or be 'work ready' was ingrained in the stories of the ECRNs and reflected in their fears of not knowing enough or being told by RNs that they did not

know what they were doing as was the case for Chris, Cathy and Susan. There are many examples of recruitment advertisements for nurses who state the applicant must be ready to hit the ground running (for example, GHR Travel Nursing, 2018; Goodwin Aged Care, 2018; HAYS recruiting, 2018; SEEK, 2018) without clarifying what this means. Chernomas, McKenzie, Currie, Care, and Guse (2010) findings into the new graduate experience of the workplace suggest that Nursing Unit Managers expect that new graduates will hit the ground running, a finding supported by others (Draper et al., 2014; El Haddad, Moxham, & Broadbent, 2013). Draper et al. (2014, p. 1307) quoted an employer involved in their study who suggested that new nurses needed to be 'fit for purpose, fit for practise and ready to hit the ground running' as if speaking about ordering a car. Some however do suggest that schools of nursing should aim to educate nurses who can think about what they are doing not just simply do as they are told (El Haddad et al., 2013; Greenwood, 2000).

In Australia, the NMBAs professional codes and guidelines are used to scope and examine practice and do not employ terminology such 'as hit the ground running' or 'work ready', but rather expect that RNs will contribute to the development of other RNs. If ECRNs are to succeed and remain within the system rather than burning out and leaving, as almost happened to several ECRNs in this study, it may be better to discuss expectations with them as a supportive measure rather than leaving them to stumble across solutions in an ad-hoc way, and left wondering if what they are doing is correct. Senior staff members may also require additional mentorship and support, regarding how best to work with and encourage ECRNs, so neither group feels overburdened and lost. This level of assistance requires multilevel support within organizations. Manley et al. (2011) use the

term person-centred rather than patient centred to acknowledge everyone's right to care and respect, including staff in their places of work.

The disorienting dilemmas and challenges described by the ECRNs focussed on the transition from student to RN and especially relationships in the workplace with colleagues (not with patients), and this was regardless of how long the ECRN had been registered and working as RNs. The transition from student to RN and the relationships encountered were complex, involving far more than the acquisition and transference of knowledge or skills learned in formal pre-registration education. The disorienting dilemmas led ECRNs to question their ontology and highlighted a discord between the reasons for wanting to be an RN; who they thought they would be as an RN and; who they were becoming once registered. It was comparing their imagining of the RN role to their ongoing experiences (Mezirow, 1991) (see figure 7.2). Becoming conscious of this was an important element in how ECRNs stay and is discussed in the following section.

How They Stay?

ECRNs were asked about how they remained working as an RN, and this section will examine that element and the threads that ran through their stories and the disorienting dilemmas they encountered. ECRNs spoke of the ways they moved through their disorienting dilemmas resulting in the decision to stay. What ECRNs in this study consistently demonstrated was a realisation of the need to reorient and transform their perspectives to develop more accurate frames of reference to, as Annabel stated, 'make the profession work' for them. This reorientation was approached in different ways depending upon the ECRN and the context in which they found themselves, but all relied

heavily on critically reflecting on disorienting situations and engaging in dialogue with self and others. The threads and contributing strands identified in this study are outlined below.

Thread: Supportive Relationships

Imperative to working as an ECRN is entering new relationships, with patients, colleagues, supervisors, other health care professionals and the community. At the same time ECRNs were maintaining their existing relationships. Just as the unexpected nature of workplace relationships led to disorienting dilemmas for participants, supportive relationships provided a means by which they could move through them. The supportive relationships that featured in the stories of the ECRNs forming the strands, included relationships with experienced RNs, peers, family, nursing and non-nursing friends and these will be expanded upon in this section.

Strand: Relationships with experienced RNs

All ECRNs stories mentioned interaction with more senior and experienced RNs as a helpful way of navigating their disorienting dilemmas. These included informal and formal relationships and ranged from ECRNs observing the behaviours and actions of other RNs, through to mentorship and formal supervision.

Claudia thought mentors in the workplace were important, describing them as the people who had 'faith' in her ability to succeed. She spoke of one of the educators she worked with following the disorienting dilemma described in her story involving a medication *near miss*. She said that this RN was very different to some RNs she had worked with, who seemed to be waiting for her to make an error. For Helena role models were

approachable and calm, could listen and respond to situations by providing honest, critical feedback without being judgmental and were able to articulate what they expected of her, demonstrating their confidence and comfortableness in speaking with people. Jon spoke of a manager he had observed and come to respect because of the way she made decisions that were fair and considered rather than simply reactive and in the spur of the moment. For Jon, this offered another way of approaching situations where he could see the way this manager listened to people considering many positions before coming to a decision. Liz was impressed by many of the nurses she worked with during her rotation to the mental health unit, whom she said had demonstrated excellent communication skills with patients and who could explain complex issues in a way that was understandable while maintaining the patient's sense of dignity. Liz concluded that much of what she learnt from those mental health nurses she could apply to any area of nursing. Polly found discussions with her mentor, an experienced community nurse a valuable source of support. Polly highlighted the importance of trust, confidentiality, honesty and respect in any mentoring relationship. She suggested that because her mentor took the role seriously, she was interested enough to give honest and critical feedback and not simply agree or dismiss what Polly said.

ECRNs spoke of actively seeking feedback as a way of improving their practice. Claudia and Helena frequently sought feedback from educators and colleagues but rarely received any, and it was not until they encountered crisis situations that feedback was provided. Jon valued feedback and engaged in discussions with a previous lecturer, who he observed was carrying out her role effectively.

ECRNs spoke to and reflected with people they respected and trusted to provide honest feedback rather than just agreeing with them. They stressed the importance of conversations that were factual, not morally judgemental and facilitated them in viewing their experiences with objectivity and where feedback was delivered in a way that assisted them to feel respected and valued as fellow human beings. Through honest feedback and discussion with others, ECRNs were learning to analyse situations rather than feeling that their identity was being challenged. In these supportive relationships, ECRNs felt that mentors were addressing the situation and not judging the person. Positive delivery of feedback helped ECRNs to view seemingly adverse situations as positive learning events. This offered the potential to reorient perspectives by learning to question their assumptions and facilitate ways to develop more valid and accurate frames of reference and discover how these could be enacted that in the workplace.

Strand: Relationships with peers

Relationships with peers (ECRNs) was a particularly important aspect of reflecting on situations for the ECRNs. Participants expressed the view that other ECRNs understood the nursing context, and could empathise with the challenges faced. Cathy spoke of the importance of being able to speak with a peer at times when things seemed difficult or when she felt she had *stuffed up*. She used social media to communicate with ECRNs she had studied with at university, citing these as robust and enduring relationships due to shared experiences. Social media platforms provided her with a valuable tool for staying connected, sharing experiences and receiving feedback quickly, which helped to normalise situations and her responses to them. Chris spoke of meeting with friends from university for coffee now and then, although this had become more difficult as the years passed due to working in different areas and on different rosters. Liz lived with

three other ECRNs and said that informal *debriefing* was a regular part of the day when she arrived home after her shift. Living with other ECRNs, she said provided the opportunity for feedback and encouragement and the chance to discuss things she could not speak about to non-nursing friends. There was a shared understanding or frame of reference for what each of the ECRNs was facing in the workplace. Liz concluded that the decision to share a house with a group of ECRNs was a good one as it offered her more than merely a place to live. Sarah said that having five ECRNs in the new graduate program who were around her age (24) was helpful and they would frequently *check in* with each other to share and compare experiences. This informal discussion was an essential part of her learning about working as an RN, and she said at work another ECRN was often the first port of call for advice before checking with a more senior RN. Socialising with other RNs was also seen as a way of managing the stress she experienced in the workplace.

Strand: Relationships with family

Claudia found that critical discussion and dialogue with family was an important part of reflecting on events and helping her to view her experience in ICU with objectivity. Helena frequently referred to discussions with her father and aunty who she said helped her see different possibilities. Jan said she often discussed workplace issues with her husband, as did Polly. The disorienting dilemma Polly described in her story however, involved sexual harassment and she did not feel comfortable discussing this with her partner thus denying her that avenue of support. Samuel's wife and father in law were health professionals, and Samuel found discussion with them helped to lighten his mood, despite the gravity of the situation. Liz said she often spoke with her mother; a nurse,

about situations and this was sometimes quite emotional. Cathy spoke with her mother, also a nurse about situations she experienced at work.

Strand: Relationships with non-nursing friends

Participants spoke of discussions with friends who were not nurses or health professionals, although this tended to be the ECRNs who had been registered for between three and five years. Annabel came to new realisations during conversations with a close friend visiting from overseas and following a crisis at work that caused her to evaluate her situation critically. She said that speaking with colleagues in the workplace was not helpful as they tended to be engulfed in a culture that was toxic and this was echoed in their conversations and advice. Speaking with a trusted friend allowed Anabel the opportunity to reflect critically with someone who sat outside of the situation and could offer a sounding board and sense of objectivity.

Thread: Learning to be in the world as an RN

Being a nurse is about being in the world, formed through interactions with others and the associated experiences. The ECRNs in this study said their pre-registration education prepared them to work with patients providing knowledge and skills; the epistemology of the profession. Their ontology, however, was less clearly defined or understood because they could not be registered nurses until they had registered and commenced working in that role. This meant there was a gap between imagining what it was to be a nurse and the experience of being a nurse; a disorienting dilemma (see figure 6.2).

The need to develop realistic expectations by examining assumptions, rather than meeting the expectations of others was an essential part of being in the world as an RN.

Annabel spoke of realising that she needed to make the profession work for her. Claudia realised that in attempting to fit in and seek approval, she was putting patient safety at risk. Samuel reoriented his expectations about what he could realistically achieve at work, concluding that if everyone leaves because they cannot nurse in the way they expect to, then no one will be left. ECRNs in this study moved past the need to understand and meet everyone else's expectations and the exhausting task of attempting to be all things to all people, which left them feeling stretched, burnt out, inauthentic and unable to meet their own needs and reasons for entering the profession. Instead, the ECRNs realised the need to develop an understanding of their ontology and become comfortable with their developing identity. This process involved bringing into consciousness the issues faced, reconciling who they thought they would be with and who they were becoming. Although the development of their identity and incorporating the role of RN commenced with pre-registration education, learning to be and work as a nurse started on the first day of employment as an RN and reconciling the assumptions about the imagined self; what it would be to nurse, with the experience of working as a nurse. This reconciliation involved merging or constructing their identity rather than merely applying a set of skills to a variety of situations. Commencing work was learning how to be in the world incorporating the RN role, discovering a new normal and how to live as that person.

When faced with a disorienting dilemma ECRNs used and developed strategies and coping mechanisms both intrinsic and extrinsic, internal and external which included technical approaches as well as more emancipatory approaches occurring simultaneously but not necessarily in an integrated way.

Strand: Making it work for me

Expectations of nurses featured in ECRNs discussions and had developed over many years; as children, through media representations, as students, during workplace experiences and then in the health care setting as RNs. Having the job 'work for them' meant ECRNs needed to examine the expectations they perceived were placed upon them from others, particularly from colleagues and managers. Through critical reflection involving discourse, Annabel came to realise that many of those expectations were unreasonable, confining her practice rather than helping her to succeed. She came to realise that she could not and did not need to meet the unrealistic expectations placed upon her by colleagues and managers. Becoming conscious of those expectations Anabel could evaluate them and develop expectations that were more accurate, reasonable and achievable. She concluded that in this way she was able to make the profession work for her, rather than just resigning; it allowed her to regain agency around her immediate situation. Regaining agency meant that Anabel felt she had to take some responsibility for what she described as burnout and setting her own realistic expectations, including caring for herself.

It was through reflection, discourse and dialogue that Annabel was able to find and remember *what she loved about the job*, thinking beyond her immediate situation. As she matured professionally and personally, she came to a clearer understanding of herself and said she was able to let a lot of things go. Clearer understandings of herself helped her to prioritise and place the patient at the centre of her practice rather than trying to meet unrealistic expectations of others, driven by a need to fit in. Annabel said she came to understand the importance of human connection, acknowledging that as a

nurse she was giving but was also gaining something and learning from patients, admitting that she could continue to give because she never knew what she would receive. This transformation in her frames of reference arrived at via dialogue and reflection, provided renewed motivation for Annabel to work as a nurse.

By critically reflecting and speaking with her aunt and father, Helena came to appreciate that trying to please others and meet the expectations of many was exhausting and not always beneficial. She came to recognise the need to construct expectations based on careful evaluation of the available viewpoints. Understanding herself and her limitations, recalling previous disorienting situations that she had lived through was important for Helena. Critical reflection and honest discussion about those situations provided Helena with the motivation and ability to view her disorientation with some objectivity and know she could move through and beyond the immediate situation, learning about herself along the way.

Samuel and Han spoke of clinical supervision and the vital part it had played in their ability to navigate the workplace, to critically reflect on their place within it and to move through their disorienting dilemmas. Clinical supervision is described by the Australian College of Mental Health Nurses (ACMHN) as a 'formally structured arrangement to support staff in human service agencies' (Australian College of Mental Health Nurses, 2013, p.1) to reflect on situations experienced as part of their professional work (Driscoll, 2007). Many health professions including nursing and social work use clinical supervision (the Australian College of Mental Health Nurses, 2013). Clinical supervision was available to Sarah, but the onus was with her as a new graduate nurse to organize it and attend sessions outside

of work hours. Sarah found that despite organizing to meet a clinical supervisor, she had been unable to find the time to attend as she said *something else always came up*. Not prioritising such supports may relate to her lack of knowledge and experience of clinical supervision; it is difficult to value that which is not understood. Competing priorities such as expectations of the workplace including demands to work overtime took priority over something that was unknown, needed to happen outside of work hours and may or may not be helpful. The ability to engage and commit to a process, adult learners need to be able to see the relevance and value of the activity (Knowles, 1973). TLT acknowledges the central role of past emotional experiences in learning and decision making where learners highlight some choices and eliminate others (Mezirow, 1991).

Strand: Fitting in

Balancing the desire to fit in with new colleagues against the need to work effectively as an RN was a challenge spoken of by most ECRNs in this study and was related to managing their expectations. Through their stories, ECRNs described situations where they felt excluded and isolated in the workplace, and their abilities to work as RNs were questioned, alongside the need to prove themselves to colleagues. They spoke of being humiliated in front of other staff as students and then as ECRNs and feeling they were nobody at work or a burden on colleagues and to the area in which they worked. Fitting in and belonging has been described as a universal and basic human need to aid in psychological well-being (Borrott et al., 2016; Mohamed et al., 2014) which involves a cognitive process that occurs through interactions with others that are pleasant (Baumeister, 1995; Hershcovis et al., 2017). Gaining a sense of belonging and fitting in is important because people place importance on group memberships (Baumeister, 1995; Hershcovis et al., 2017) because it has the potential to offer a sense of security, status

and a way of participating in the life of the group (Baumeister, 1995; Hershcovis et al., 2017). Lacking a sense of belonging is associated with an individual's perception that they are not valued (Baumeister, 1995; Hershcovis et al., 2017). ECRNs perceived that to fit in, they had to meet the expectations of others in ways previously explained.

ECRNs stories revealed attempts to balance the need to belong with the desire to advocate for people in their role as RN which often seemed in opposition. Becoming conscious of this was sparked by the disorienting dilemmas described in the stories of the ECRNs, leading them to examine and evaluate their ideas, beliefs, assumptions and perspectives to allow them move through the dilemmas. Identifying the need to balance belonging and advocacy highlighted the complexity of the transitional and transformative process and the significant learning involved. This learning often requiring soul searching and heartache, borne out through the stories of the ECRNs in this study and that on all occasions required relational support to help them manage the process.

Strand: Learning to be me.

When faced with situations that are highly challenging, such as commencing a new career, stress (Gardiner & Sheen, 2016; Laschinger et al., 2016) and disorientation are likely to occur. In this study, support helped participants move through disorienting dilemmas and transform their frames of reference and perspectives. Approaches and strategies used by the ECRNs in past circumstances to manage disorienting no longer applied because the environments and roles were new and therefore had no connection to situations previously encountered. Through their stories, participants explained that they had not expected the transition into the RN role to be simple, and challenges were anticipated but it was the nature of the challenges and the reactions of others that led to

disorientation. Finding and accessing support, both internal and external, was important as was learning how to best use the support in a given context.

ECRNs reflected critically on their assumptions to become conscious of the premise underlying their disorientation. This involved the examination of their perceptions, unquestioned assumptions and unfounded and imposed expectations. In critically evaluating the imposed expectations of others they were able to develop their own more considered and accurate expectations, regaining a sense of agency; becoming strategic rather than reactionary. This is a move toward emancipation as people are freed from the constraining ideas, values and judgements of certain individuals or groups (Habermas, 1984; Mezirow, 1991). Claudia recalled how hard she had worked to complete her nursing degree, remembering she had always had faith in her ability. This belief was reinforced by an educator who had worked with Claudia following a medication error and telling her she believed she would get through her new graduate year. Helena knew she was not as bad as some of the ICU nurses made her think she was and conversations with her aunt and father helped her to become conscious of her attempts to meet everyone else's expectations which she came to realise was not possible. Chris found authenticity in her advocacy work both in and beyond the workplace. In becoming emancipated from the expectations of others or imposing expectations on patients, Anabel came to see that she was learning from the people she cared for and how the act of listening was making her a better nurse. Han realised through conversations with clients that listening was often the most significant thing could do for someone else and Cathy realised that being in the moment with patients meant connecting with them in ways that others might consider insignificant.

Conversations such as these caused the ECRNs to look at situations differently where their perspectives could be transformed and by learning about themselves they were also learning about authentic ways to be RNs the workplace.

Strand: Choosing your battles

Participants spoke of new perspectives related to the way they managed situations in the workplace; moving from confrontational approaches to more considered and strategic ones by taking the time to reflect critically on their reactions to situations. Engaging in dialogue with trusted others and in some cases observing how others in the workplace effectively managed certain situations, participants could see and imagine alternative possibilities; an essential part of adult learning.

Jon's experiences of isolation in the workplace in response to his attempts at advocacy caused him to reflect on the way he had approached this. In one instance he questioned a staff members behaviour toward him discussing the issue with the unit manager. Following the incident, the staff member who was aware of the discussion refused to inform him of relevant patient information. When he reported his manager for referring to patients in a negative and demeaning way he found himself isolated and excluded from conversations and meetings. Jon discussed these situations with a former lecturer whom he trusted and who advised him that change occurs slowly. He also spoke of a manager who worked in the facility where he was working, observing her approach and interactions with staff, describing her as someone who took time to consider various views before making decisions that were valid and effective. Discussions with someone trusted and observing the practice of others led him to reflect on his approach critically. This process brought him to new perspectives about his actions and who he was in the

world, developing the ability to imagine and experiment with more effective ways of advocating for those he worked for and with. Jon believed that by increasing his knowledge and understanding through further study and gaining broader experiences by working in a variety of organizations, he would also increase his credibility.

Faced with the decision of whether to leave her employment or not, Jan reached a point where she needed to consider the issues she was facing with her supervisors at work regarding her leadership style. Critical reflection and dialogue with self and others, including prayer, directed the process of moving to a position that provided her with a degree of objectivity, examining her leadership style to evaluate its effectiveness. In this way, she could identify the positive affect her transformational leadership style had on those she was leading, compared to those who chose different and more autocratic methods.

The threads that emerged concerning *how ECRNs stayed*, centred on how they examined, negotiated and transformed their frames of references. ECRNs spoke about the impact of relationships in and outside of the workplace and about learning to be themselves as they learnt how to be in the world as an RN. The overarching theme that emerged from the threads discussed above was the centrality of intersubjective relationships to the learning of ECRNs and how this enabled transforming of perspectives and the development of more accurate frames of references leading to authentic ways of being.

Why they Stay?

Thread: Making a difference?

All ECRNs stories spoke about their reasons for becoming nurses and these centred around the desire *to make a difference* to the lives of others or to *give something back* to society but there were also practical reasons. When examining the threads in this study, I commenced by investigating why the ECRNs had decided to become nurses and what they thought it would be like to be a nurse; this was done to help identify and acknowledge the context. In looking at these two elements however, a strong link emerged between why the ECRNs wanted to be nurses and why they stayed. The stories suggested that ECRNs stayed for the same reasons they entered nursing in the first place. It is important therefore, that these elements be discussed together in this section. Support was necessary and provided the means to transform perspectives and develop more accurate frames of reference to help ECRNs reconnect with the reasons they entered nursing. Their reasons for entering nursing however were based on their pre-registration frames and reference and imaginings of what a nurse is and does and support was required to help them re-evaluate those in the face of their experiences post-registration as they worked as RNs. In viewing their role realistically, ECRNs could begin to learn how to grow toward authenticity and incorporate their role as RN with their developing identity. These will be discussed in the following sections commencing with the practical reasons as to why they stayed.

Strand: Practical reasons

Practical reasons and perceived employment security factored in the decision of this group of ECRNs to enter nursing but in all cases was not the primary reason given for why

they stayed. Susan, Claudia, Polly, Helena and Jan believed that nurses would always be able to find work and transfer their skills across contexts and geographical areas, implying a desire for a financially secure future. Such pragmatic approaches included the perception that work in nursing was available and was fuelled by media and other reports of nursing shortages (Australian Broadcasting Commission, 2008; Calderwood & Miskelly, 2018; ICN, 2006; NSW Nurses and Midwives' Association, 2018). The transportability of nursing and portrayals of nurses in television dramas influenced Polly's decision to study nursing as she felt it looked like an interesting job, although this was more a catalyst to move forward, having considered nursing as a career since leaving school. Jan's business suffered financial challenge during an economic downturn and she concluded that she could move her business to another city or enrol at university and pursue a career change; she decided to go to university and become a nurse. Liz, Susan, Jon, Helena and Claudia all spoke of the variety and opportunities offered by a career in nursing with numerous areas of specialisation in which nurses worked. Practical reasons were important in providing an income and the ability to undertake more altruistic ventures but in all stories their reasons for staying transcended the practical regarding why they entered and why they remained in the nursing profession.

Strand: Making connections

Mezirow (1991) suggests that learning is not only about language but includes perceptions or pre-reflective learning that occurs before the use of language allowing the formation of categories. This type of learning incorporates an executive sense of agency and the capacity 'to make decisions independent of socially imposed expectations, assessments or conditions' (Mezirow, 1991, p. 16) and is located in the prelinguistic domain. By drawing on past knowledge and prior learning, people make connections and

relate ideas that delineate the boundaries of possible new experiences. This connection is what Mezirow (1991) defines as perceptions; it involves imagining what a new experience will be like. The ECRNs in this study chose to become nurses based mainly on what it would mean to them and how working as a nurse could potentially meet their needs, and how they might use it to enact their values. It was based, not on articulated understandings of what a nurse does but instead on their perceived representations of nurses in the world. Annabel recalled her trip to the Florence Nightingale museum as a small child, impressed with the starched white uniforms; Polly spoke of media representations of nurses and their work; Liz talked about discussions with her mother who was a nurse; Cathy had observed and been impressed by the work of nurses during frequent visits to hospitals with her sister and; Susan had observed the work of practice nurses during her time working as a receptionist in a GP surgery. These types of experiences had helped the ECRNs in this study to continue to form their frames of reference and build their perceptions of what it might be like to be a nurse. The memories were relayed to me with clarity and fondness demonstrating the powerful links that those memories created (Mezirow, 1990).

Of becoming a nurse, several ECRNs said they had not known what to expect, but all could articulate why they wanted to become a nurse. This finding is meaningful because it poses the question 'can we seek to become something when we believe we do not know what to expect?' Even Annabel who had been an EN for ten years before registering as a nurse could not identify what being an RN would be like but could speak about being ready to take on more responsibility and have more say in the care of patients. Although ECRNs were unable to articulate their expectations of being a nurse, their reasons for

entering the profession suggested what they ‘wanted’ a nurse to be and these were based on the representations of nurses in the media, those they had observed during interactions in the healthcare setting and discussions with family members who were nurses or health care professionals.

Strand: Do some good

Participants declared reasons for choosing nursing as a career, such as wanting to make a difference and the opportunity to give something back to society. Some participants felt their previous careers had not allowed this. Following high school, Helena just knew she always wanted to do something in the health field. Sarah said she felt unable to make a difference in her previous job but thought that as a nurse she could, as did Chris. Jon spoke of his need to give something back to society following the death of his sister, and Samuel and Jan talked of the importance of their values in guiding them into nursing. Han believed that at some point in the future she might be able to impact the quality of mental health care for the people in her home country. Liz spoke of wanting to make things better, and Polly wanted to help people. While they did not use the term, their intent aligns with the concept of altruism.

Carter’s (2014) findings suggest that nurses come to practice based on altruistically motivated practice which is culturally rather than spiritually bound. Altruistic reasons for entering nursing are supported in other studies (Baskale & Serçekus, 2015; Eley, Eley, Bertello, & Rogers-Clark, 2012; Eley, Eley, & Rogers-Clark, 2010) and suggest the motivation may be as much about what is received as what is given. Mimura, Griffiths, and Norman (2009) suggest altruistic reasons for entering nursing might be an attempt to compensate for a negative self-concept and self-esteem, suggesting,

that those who want to be professional nurses may unconsciously try to compensate for their low self-esteem by caring for others. That is, they may have an underlying need to help people and to be rewarded for so doing through expressions of gratitude (p. 604).

Annabel and Cathy spoke however of their need to move beyond expectations of patient gratitude to nurse more effectively.

The ECRN stories indicate that upon commencing work as RNs, their perceptions and experiences did not align. Considering that perceptions rely on imagining and are filtered by a person's frames of reference, this threatened their concept of identity, leading them into a disorienting dilemma. This disorientation forced the ECRNs to examine their expectations and underlying assumptions to determine how to transform their perceptions to build more accurate frames of reference, weaving the RN role into their identity on the journey to authentic ways of being. This process included accepting that learning was an ongoing process, and identities were never stable because they were always adapting to change (Illeris, 2014b); It was learning how to live with change.

Strand: Enacting values

When considering *why ECRNs stayed*, the strands harkened back to the reasons they identified for choosing nursing as a career and related to an overarching theme of altruistic intent and the desire to enact their values. Jan spoke of her personal values as fundamental to the way she treated others, influencing her person-centred approach in the workplace. Jan admitted this had developed from living a *tough* life and knowing what it was to be *treated poorly* not wishing to replicate this for others. Samuel said that his decision to enter nursing was related to his values which was emphasised when he

had been the recipient of care. He said that nursing *struck a chord with his values of service*. Once enrolled in a BN, Samuel found it difficult to align his values with those of nursing, choosing to leave the program for a time, before returning to complete it. Since working as an RN Samuel had experienced positive experiences, which he said *affirmed those values* and was a key motivator for him continuing.

In reflecting on their workplace relationships and the expectations placed upon them by others and themselves and learning not to accept these blindly, they were developing more accurate expectations and learning about who they were as people and RNs. This process involved bringing into consciousness the importance of and enjoyment discovered in human connection and being with patients and clients; it was transforming their frames of reference. Transformed frames of reference, offered ECRNs the opportunity to enact their values although in different ways to those imagined. Becoming conscious of and working through their disorientating dilemmas, ECRNs could reconcile the imagined with the experience and move toward more authentic ways of being. This transformation was also impacted by each of the ECRNs growing levels of experience and confidence to live the role of RN enhanced through more accurate expectations.

Thread: Being with others

Being with and learning from others and sharing their journey were often mentioned by participants as reasons to stay.

Annabel spoke of experiencing a defining moment in coming to understand what patients could teach her. Cathy spoke of the sense of privilege she felt in being with people at

significant times in their life and how overwhelming it was when patients expressed their appreciation for the things she did as a nurse, especially the small things such as being positive, smiling or listening to the person. In the clinical setting she said these are often seen as insignificant and not always valued by those working in technologically and task driven areas of nursing. She recalled being told by a person she was caring for that those seemingly *insignificant* things made a difference and it reminded her of why she liked being a nurse because she said she liked being that person. The ECRNs appreciated sharing parts of the journey of those who they cared for. Jan, Cathy and Jon all spoke of the enjoyment in being witness to and sharing the journey of the people they worked with as nurses. Jan spoke of wanting to bring kindness into the workplace because she had found it was often lacking and that nurses were not always caring despite nursing being labelled as the caring profession and Susan spoke of the excitement she felt in witnessing a patient success that she had helped to facilitate.

Liz said she stayed because she felt that one day things would be better in the workplace and she wanted to help that to happen. Jon aimed to give something back by helping to improve the experiences of the people he worked with, residents and staff in the aged care and dementia settings. Claudia, remembered the good that she was doing stating that helping people is one of the greatest things that someone can do. Similarly, Chris identified working with patients when they were at their worst as the most important part of her job and the sense of responsibility she felt to help maintain their dignity and personal relationships. In responding to the question why do you stay Susan said simply, that she liked her job. Expanding on that response she said she liked the feeling that she was making a difference to the lives of others.

Han hoped that she might make a difference in the mental health sphere in Australia but also wanted be able to take much of her learning and experience about mental health nursing to her home country to improve attitudes and care of that population. Advocacy for those without a voice in the health care system was an important element of Sarah and Chris's decision to stay in the nursing workforce with Chris extending this to her ability to advocate to other staff members particularly those new to nursing. Samuel pointed out that if everyone leaves because of challenging situations who will be left?

One of the main reasons that participants chose to stay was discovering the value in being with other people but this did not happen immediately or seamlessly and involved becoming conscious of and free from imposed expectations. Moving beyond those expectations ECRNs could see what it was to be a nurse, to live as a nurse and connect to others through a shared humanity.

Conclusion

In this chapter I looked inward to explore the ECRN stories, identifying and examining the strands and threads that move through and across them. Disorienting dilemmas experienced by participants resulted from the transitions and integrations into their new role as RN, intensified by difficult workplace relationships including imposed and unfounded expectations. This was further intensified by the incongruence between the imagined self as RN and that which they were experiencing. These findings highlight the first theme that will be discussed in Chapter Seven; challenges to the developing identity of the ECRN resulting in disorienting dilemmas. The exploration of how ECRNs stay

demonstrated that engagement in supportive, intersubjective relationships and learning to be in the world as an RN were the ways that ECRNs faced and moved through their disorienting dilemmas. The themes drawn from these threads include, the significance of intersubjective relationships in providing support to ECRNs and becoming authentic. The question of why ECRNs remain in the workforce aligned closely to their reasons for deciding to become nurses and the desire to make a difference to individuals and society and enact their values through nursing. It was through intersubjective relationships that ECRNs were becoming emancipated from unfounded assumptions moving toward authentic ways of being and discovering the value and importance of human connection to nursing. The themes that emerged in relation to why ECRNs stay included the discovery and value of human connection and altruistic intent. As a result of their developing authenticity and the discovery of human connection, ECRNs came to understand how they could best meet their altruistic intent although this may not have been in ways imagined. In Chapter Seven I will explore the themes in more depth, looking inward to the stories of the ECRNs and outward to other evidence that connects the ECRNs experiences in this study to the world beyond it.

Chapter Seven. The fabric of the thesis: the themes.

In this chapter I discuss the themes woven from the threads identified in the ECRNs' stories and examined in Chapter Six. Table 7.1 shows the relationship between strands, threads and themes in this study. ECRNs were able to move through their disorientation and toward authentic and emancipatory ways of knowing and being through intersubjective relationships. These relationships offered ECRNs an epistemology and safe places to engage in dialogue and enter into processes of critical reflection on their experiences. In these spaces, ECRNs were able to question perceived expectations from and of others and begin to understand how their RN roles were integrating with their identity and becoming a part of their ontology. This process allowed them to become conscious of and test the assumptions that underpinned their frames of reference regarding nursing, aligning what they imagined it would be like with what they had experienced; it was the journey to the authentic self and how the RN role was becoming a part of their identity. Intersubjective relationships and reflective processes, enabled, ECRNs to become conscious of the importance of human connection and the way it allowed them to enact their altruistic intent by reconnecting with the reason they decided to enter nursing, which was also the reason they stayed.

Strands, threads and themes across ECRN stories			
Element	Strands	Threads	Themes
Disorienting Dilemmas and challenges	<ul style="list-style-type: none"> • The transition from student to RN • The new graduate year • Being in the workplace • Workplace relationships • Responsibilities and expectations 	<p>Transitions and integrations</p> <p>Relationships in the workplace</p>	Challenges to the developing identity
How they stay?	<ul style="list-style-type: none"> • Relationships with <ul style="list-style-type: none"> ○ experienced RNs ○ peers ○ family ○ non-nursing friends 	Supportive relationships	Intersubjective dialogue and relationships
	<ul style="list-style-type: none"> • Making it work for me • Fitting in • Learning to be me • Choosing their battles 	Learning to be in the world as an RN	Becoming authentic
Why they stay?	<ul style="list-style-type: none"> • Practical reasons • Making connections • Wanting to make a difference and to help people • Do some good • Enacting values 	Making a difference	Altruistic intent
	Sharing the journey of the patients / clients	Being with others	Human connection

Table 7.1: Relationship between strands, threads and themes

Theme: Challenges to the developing identity

The story of Ezri: a parable (continued)

*... A voice in his head told him to be calm but his heart
raced.*

*Ezri had read about this place and spoken to many others
about it. They had talked in depth about what it was like to
be there, the way they felt, the sense of unknowing, the
insecurity. He thought he knew it and that the things people
told him and the reading he had done had prepared him. He
had chosen to come. He thought he had been ready but, in
that moment, lost to time, he had no idea what might
happen next. As light slowly began to infiltrate the darkness
and his pupils began to accommodate, unblinking he looked
and stared and realized nothing had prepared him for this.*

*In the half light, nothing was clear, everything seemed faded
and merged. There was movement but he could not tell
what it was that was moving and the hum had become less
like wasps and more like a cacophony of voices that was
indecipherable.*

*He was frightened, moving more and more quickly as
ghostly images sped toward him. He dodged from side to
side trying to get out of their way, whatever they were – it
all felt out of control and his brain buzzed adding to the
background voices that held no meaning.*

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The stories of ECRNs told of how they moved into the healthcare system as RNs, expecting to find spaces and roles they imagined would be familiar. They were spaces that ECRNs had practised in as nursing students, but in their new roles, they discovered them to be unfamiliar and this resulted in disorientation and uncertainty about who they were and how to be. Being in the workplace involved ECRNs becoming wakeful to who they had thought they were, who they had imagined they would be, and who they believed they were becoming. This journey of discovery involved exploring their frames of reference and the way their existing perceptions and perspectives threatened their sense of identity. The development of identity is not a linear or straightforward process but an evolutionary and iterative one (Scanlon, 2011) involving the visiting, questioning and debunking of assumptions.

Embarking on a new career is challenging and stressful (Laschinger et al., 2016; McKillop, Doughty, Atherfold, & Shaw, 2016) involving adjustment to new workplaces, new relationships and new roles. All these stressors were spoken of by ECRNs through their stories. There was a need to apply technical skills, and knowledge learnt at University and at the same time make sense of what it was to be in the world as an RN. As ECRNs learnt about nursing during their undergraduate study, their frames of reference continued to form as they imagined who nurses were, and what they do. In this imagining, the ECRNs added to their expectations of how nursing could help them achieve their aims including the desire to assist others and give something back to society through their actions as a nurse. It was not until commencing work as RNs though, that they could begin to know what it actually meant to be an RN. Jarvis suggests that initially nurses 'play' their role but gradually this is 'transformed into an ontological state and while the

end-product is recognized the process of learning that state rarely is' (Jarvis, 2006, pp. 49-50). ECRNs described the vast chasm between being a student and being an RN and the unexpected heavy weight of responsibility accompanying the role that was unknowable until experienced. It was chasms such as this and the incongruity between the imagined and the experienced that triggered disorienting dilemmas and the need to find meaning through experiences.

ECRNs described situations where work and other areas of their life blurred, with no clear delimitation, all facets of their life were intricately interwoven and impacted on the other. It is essential at this point to reaffirm the way identity is used in this thesis. The term identity is recognised as an academic concept but is also used in general language (Illeris, 2014a). Roth suggests that 'one of the mysteries of human identity revolves around the question of how we come to be what we are' (Roth, 1990, paragraph 1). Since Erikson's (1968; 1982) work, identity has come to be understood as a psychosocial concept that acknowledges the impact on development of interactions between individuals and their social environment (Candy, 1989; 1991; Illeris, 2014a; Mezirow, 1991). Some authors view individuals as possessing numerous identities that exist for 'wearing and showing. Not for storing and keeping' (Bauman, 2004, p. 89) or explaining identity as something divided into discrete sections, such as the professional or personal identity (Mazhindu et al., 2016; Traynor & Buus, 2016; Willetts & Clark, 2014; Yazdannik et al., 2012). Ramarajan and Reid (2013) write about individuals having multiple identities but challenge the concept that the 'work identity' can be separated from the self and the personal identity, as each is a result of the integration of the other, heightened by the blurring of work and non-work life domains. Identity has internal psychological and

external relational aspects that develop and change over time dismissing the notion that identity can be stable (Illeris, 2014b). In this study, the term identity refers to a synergistic whole that is formed by the construction and interweaving of the ECRNs' frames of reference. In line with constructivist ideas, identity is seen as the perception of the individual, not a judgment to be made by others.

Illeris (2014b) suggests that transformative learning transforms identity. The identities of ECRNs were threatened when they realised their imagined ideas of being a nurse did not align with their experiences of working in the role. This, in turn, challenged what they thought they could achieve as a nurse, undermining the very premise for becoming a nurse in the first place. This premise had been strengthened over the years, as their frames of reference continued to develop during university. The threats emerged as disorienting dilemmas, and ECRNs responded by engaging in critical reflection and dialogue, examining, questioning and aligning what they had imagined or assumed nursing would be like with their experience. This awareness resulted in a need to reorient their frames of reference leading to perspective transformation and transformation of identity. Transformation resulted in changes to the way they thought about who they were becoming and how to make the job work for them and allow them to nurse in a way that they found acceptable although different to what they had imagined, enabling them to meet their altruistic intent. This process was the journey to becoming authentic.

ECRNs described challenging relationships with managers, supervisors and co-workers that were catalysts for disorienting dilemmas. There were situations where they felt a need to prove themselves to other RNs and meet many, perceived and often unexplained

expectations. Feeling and being told they were incompetent, that their education had not prepared them to be an RN and being ignored, discounted the ECRNs (and adult learners) experiences, thus projecting a disregard for the ECRN as a person from supervisors and co-workers. Experience is integral to an adult's identity and their development (Merriam & Bierema, 2014) and unlike children, adults define themselves by their experience. When experience is devalued or ignored by others, it may be perceived by the adult as a rejection of their experience but also a rejection of them as a person (Knowles et al., 2011). ECRNs spoke of feeling disempowered and in some cases felt they were a burden to those in the workplace. Being excluded from career decisions that impacted their lives or the lives of their families and significant others, rendered ECRNs voiceless and without agency. The loss of agency combined with supervisors who did not attempt to know or understand the ECRN, relegated them to object status. When people are treated as objects, they lose power within the relationship (Mezirow, 1991, 2003). When elements of a person are discounted or misunderstood disharmony results, and the person is left to try and re-establish their internal harmony (Jarvis, 2006). This destabilisation and discomfort brings into question a person's identity (Cranton, 2016) and for the ECRNs triggered disorienting dilemmas leading into a process of transformative learning and the questioning of the assumptions upon which their frames of reference were built.

Theme: Intersubjective relationships and dialogue

The story of Ezri: a parable (continued)

From behind him a voice, brusque, not angry but as clear as any he had ever heard asked, 'What are you? Who are you? Why are you here?' He spun around not knowing if he should answer. The voice came from a shape in front of him which was also a blur but unlike the others was still.

My name is Ezri he said. I came to help. And explained how he would do that and his expectations in coming. He said 'But I can't see or hear anything clearly. Everything is in shadows'

'But I can see you and hear you' the voice said.

'But who are you?' Ezri asked

'My name is Alfrida.'

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ECRNs' stories described relationships where, as students, they were relegated to object status leading to disorienting dilemmas, but it was in and through intersubjective relationships that they were able to move through their disorientation. Intersubjective relationships are about seeing and attempting to understand another, based on the fundamental premise that it is humanness that connects people (Habermas, 1984). It was through intersubjective relationships and dialogue that ECRNs critically reflected

upon their experiences, learning about themselves and beginning to make meaning of what it was for them to be a nurse and for the RN role to enmesh with who they were becoming. ECRNs came to realise that many of their actions were in response to the perceived but unquestioned expectations of others and the unrealistic expectations they held for themselves. By critically reflecting, ECRNs grew increasingly conscious and wakeful of these expectations and their unworkable and debilitating nature. Freire (2000) highlighted the importance of becoming critically conscious of the facts to enable the identification and challenging of assumptions. Jarvis (2014) suggests the first step in learning is becoming conscious of unknowing. It was through this wakefulness that perspectives were transformed and ECRNs began to learn how to make nursing work for them.

ECRNs in this study entered into intersubjective relationships with people in a variety of settings and roles including, colleagues, mentors, educators, family members and clinical supervisors. What was consistent about the features of these relationships across the ECRNs' stories was the importance of trust. ECRNs wanted to feel they were respected and valued as people, knowing that their discussions and issues were taken seriously and responses to their reflections were honest and confidential. These features align with the ideal conditions for discourse that promote self-respect, acceptance of diversity and respect for others to provide an environment that is safe for participants (Mezirow, 1991; 1994; 2012; Mezirow et al., 2009). It was through intersubjective relationships ECRNs could focus on critically reflecting on experience rather than trying to meet others expectations, questioning and identifying assumptions and developing more accurate frames of reference by aligning the imagined with their experience.

The alignment of the imagined (pre-registration) ideas of being a nurse and the experience of working as a nurse (post registration) were necessary. Generally, as humans mature and have more experience, they become more adept at imagining how things might happen by linking past experiences to future ones (Mezirow, 1991). I call this consequential awareness, when based on previous experiences we can imagine possible outcomes when specific actions are taken, and certain conditions exist. Learning is an imaginative process and helps people to think about how things might otherwise be (Illeris, 2014b; Mezirow, 2009). Bruner (1957) wrote about an internal dialogue with self that occurs when constructing one's own perspectives and when thinking about the perspectives of others. This is one way that empathy can develop as people learn to look at an issue from another's view point. What happens though when people do not have the experiences with which to associate and plan future actions and behaviours as occurred for the ECRNs starting a new career? Although they had observed and learnt about what nurses do, their experience of actually working as RNs was limited. Initially, they tried to please those with whom they worked, following what everyone was doing, acting on the advice of others, attempting to prove themselves, to fit in and meet externally and self-imposed expectations. As this became too challenging and as ECRNs experience began to grow they started to question the expectations arriving at new understandings about themselves and their work. When imagination fails to be recognised as imagination, ECRNs risked becoming rigid in their views and approaches to nursing, succumbing to hermeneutic idealism where other views, beliefs or ideas are not explored or valued (Habermas, 1984; Lovat & Douglas, 2007). In such a scenario, things are done because that is what has always happened or because someone in authority

commands it; it is not authentic. By becoming aware of the misalignment between the imagined and the experienced and through the process of transformative learning, ECRNs began to develop realistic expectations by evaluating the best available evidence and planning their own goals rather than attempting to meet everyone else's. Participants needed to learn how and what to investigate to help them answer the questions of *why they came* and *why they stayed*.

Philosopher, Christian de Quinzy (de Quinzy, 2015) explains intersubjectivity as an epistemology that connects consciousness with experience and helps people to understand their ontology. His approach to intersubjectivity proposes that relationship is the most fundamental way that we can begin to know who we are. de Quinzy says this does not deny individuality but suggests it is secondary to our essential nature which is 'interbeing'. Ashman and Lawler (2008) believe the term intersubjectivity has become an umbrella term for concepts such as empathy, reciprocity, understanding and connectedness and Pierson (1998) proposes that through intersubjectivity, all forms of knowing come together, including cognitive, intuitive, experiential and personal knowing, moreover, it is in this that meaning can be made by exploring experience.

ECRNs engaged in dialogue through intersubjective relationships that involved communication between people and attempting to understand another's experience or ideas (Mezirow, 1991). Habermas (1984; 1989) refers to this as communicative action. The relationships with others were not about the role or status of the person with whom ECRNs were in dialogue but rather the nature of the relationship, the process and the way each person behaved toward the other; honestly and respectfully, while attempting

to understand and investigate the challenges and experiences of the ECRN. As advised by Pierson (1998) this type of communication occurs through active engagement and wakeful participation with others but requires balance so that nurses do not intertwine so closely with others that their autonomy is breached. An intersubjective relationship honours the interstices between individuals in the relationship, fostering shared understandings of experiences and the ability to be present for the 'other' (Pierson, 1998). Interstices are the spaces connecting lifeworlds (Ruparell, 2013) and are neutral and non-judgemental. In this space humanity is the connecting force where dialogue and critical reflection can occur. This type of communication is more than hearing the words; the listener attempts to understand the meaning behind the words, determining how and what is significant to the speaker. To participate in intersubjective dialogue requires skills, sensitivities and insights including an open mind, empathic listening and seeking common ground (Mezirow, 2003).

This study is not suggesting that disorienting dilemmas do not or should not exist or that they are avoided, but rather people need the spaces where they can become conscious of them. Clark concludes that

The interconnectedness of experience, learning, philosophical beliefs, and practice are the lattice upon which we weave our quest for knowledge and, in doing so, we give rise to the notion of celebrating moments of disorienting dilemmas (Clark, 2008, p. 48).

Intersubjective relationships provided ECRNs with the spaces to do this. These were the neutral spaces between lifeworlds where humanity connected people regardless of their

position and where judgement could be suspended, and critical dialogue could occur through being with another person; the *other*.

Worthy of further exploration is the term *other* as there is some controversy surrounding its use. The term *other* refers to a person beyond the self and avoiding intrusiveness because

to do less, is to suggest a disregard for the autonomy of others as well as the self. Consequently, intersubjectivity entails developing relationships that show sensitivity for the otherness of individuals (Pierson, 1998, p. 300).

While Habermas (1984) disputes the use of the term *other* suggesting it implies a power differential, Pierson (1998) advises reference to the *other* demonstrates respect for the space between people, acknowledging that the *other* does exist. Cranton proposes that power exists in all human relationships but by becoming conscious of it, people begin to see and understand how it is exercised and emancipation can begin to occur (Cranton, 2016) by transforming skewed perspectives. The imposed expectations described by ECRNs were related to a power difference based on their limited time, confidence and inexperience as RNs. Through intersubjective relationships and dialogue, ECRNs could become aware of the power others had with relationships through overt and covert expectations. In becoming aware of this power, and with growing experience, ECRNs could develop more accurate ways of viewing the world, based on more realistic and achievable expectations as they moved toward authenticity. The respectful nature of the intersubjective relationships brought with it an authentic power; power with, not power over (Hills & Watson, 2011). As Cranton suggests,

In the relational or connected approach to transformative learning theory, people are seen as learning through cultivating relationships with others, developing integrative and holistic ways of seeing the world, understanding others' points of view (rather than debating them), listening empathically, and nurturing and caring (Cranton, 2006, p. 76).

The ECRNs in this study found themselves at the edge of their experience and limitations. Transformative learning leads adults to the edge when a way forward cannot be navigated based on habitual responses (Illeris, 2014b). ECRNs entered the healthcare setting thinking it would be familiar as they had visited regularly as students but discovered as RNs things were not as they expected. Whilst it was the same place, they entered in a different context and found themselves navigating professional relationships with managers, supervisors, peers and colleagues in a role beyond anything experienced as students and this was unexpected.

Nursing is a relational profession (Benner et al., 2010; DeFrino, 2009; Hills & Watson, 2011; Pierson, 1998); it is about being in and of the world and with others. Polt (1999) defines *being in the world* where

...we are essentially involved in a context – we have a place in a meaningful whole where we deal with other things and people. The particular content of this context will vary from person to person, and from culture to culture. However, it can be said . . . that our relation to the world is not disinterested – it is active engagement. We are not, and never can be, radically detached from the world (p. 46).

The work of nursing is reliant on communication, reciprocity and sensitivity (Fletcher, 2001) and ECRNs discovered the types of relationships that affected them were far more

wide reaching than interactions with patients and clients but extended to all relationships, reinforcing the interconnectedness of humanity. The professional relationships encountered in the workplace led to disorienting dilemmas for ECRNs and threatened their developing identity. It was, however, the supportive intersubjective relationships that helped them to move through their disorientation and toward authenticity.

Theme: Becoming Authentic

The story of Ezri: a parable (continued)

As time passed Ezri began to decipher some of the voices and the instructions hidden in the hum. He tried to do what they told him, thinking that this would help, but he was unsure.

Every few days Alfrida would come and sit with him and ask him questions about his experiences in this place. He spoke to her about how hard it was to be in a world of shadows.

One day staring down he admitted to feeling helpless and said to Alfrida, 'This is not what I expected, my ideas are not true. I must forget them'

Alfrida asked, 'Why must you forget? You have the skills and the knowledge but who are you and who are you becoming?' Ezri thought these strange questions; he had told her who he was and why he was there.

Over time Ezri continued to speak with Alfrida, constantly questioning the wisdom of his decision to come to this place, wondering if there was a point to it. The more he thought and talked about this and continued to do what he was told, the more he was coming to see that he was not helping in the ways he had imagined and perhaps needed to give up and go back. But he also came to realise that he was beginning to see Alfrida more clearly.

Ezri continued to work and the work was challenging but he thought often about the questions Alfrida had asked and who he was becoming. Ezri began to understand that he was letting go of who he thought he would be, focusing instead on what was actually happening. He still listened to the commands of the voices but before he acted he thought about what he had learnt and what he was learning now...

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Attempting to meet the expectations of many was a significant cause of disorientation for the ECRNs in this study as they transitioned to the workplace, learning about becoming and being RNs. Through intersubjective relationships, ECRNs engaged in dialogue and critical reflection attempting to realign their frames of reference and transform their identity in ways that reflected their growing breadth and depth of experiences. The ECRNs role as RNs was becoming interwoven with their identity and enmeshed in their ontology.

Becoming conscious and wakeful of their attempts to meet the expectations of others was a step toward authenticity for the ECRNs. Trying to meet the expectations of others was an attempt to fit in and be a part of the group in situations for which ECRNs had no previous experience or where that experience was devalued; ECRNs did not know what it was to be authentic as RNs because the role was new. Although the ECRNs had heard, imagined and studied nursing they had not been an RN until the day they commenced. Attempting to meet a raft of expectations, including the ability to seamlessly move into new roles across a variety of contexts resulted in a barrier that hindered their developing identity and growing authenticity (Cranton, 2001; Cranton & King, 2003); it was a state of disorientation.

Authenticity is the expression of the genuine self in the community (Cranton & King, 2003, p. 98) and happens by being in the world and how we are in the world; it is the ontology of the person (Vu & Dall’Alba, 2011). By interacting with others and things, we form and shape who we are becoming as people and professionals; it is interbeing (de Quincy, 2015). As a relational profession, RNs must consider the way they are in the world with others.

Our being is being with others, being amidst the world we share with others and things, a world in which we dwell and make our home. Our existence is conditional upon the everyday understanding of how we go on in the world in a public way. For this reason, falling in with a crowd is part of how we live our lives. However, if we simply follow the public way at all times, there will be no space for creativity and advancement. Therefore, we must resist falling in with a crowd completely. At times,

we must call things into question, engage in renewal and explore other possibilities (Vu & Dall’Alba, 2011, pp. 97 - 98).

With a growing awareness of their disorientation and its premise, ECRNs moved to points where they could exist ‘with’, rather than ‘outside’, those in the workplace. This awareness did not mean that participants simply accepted the social norms but rather used a functionalist approach to their situation as they learned what it was to be in the world as an RN. Through this process, ECRNs were making the profession work for them allowing them to develop more accurate ideas about how they could fulfil their altruistic intent.

The ECRNs were moving toward taking responsibility for their actions as they questioned their experiences and the expectations of others. Heidegger’s (Dreyfus, 1991; Polt, 1999) concept of authenticity and inauthenticity explains that when we do things only because it is what others are doing, we are acting inauthentically. It is when we take responsibility for the way we live our lives and examine our choices and the reasons behind those choices that we can be authentic.

During workplace experiences as students, ECRNs entered and existed in the workplace but functioned in parallel to RNs, as observers of healthcare teams, rather than members. This positioning may suggest that until a person is registered as an RN, they do not belong, and their experience is neither credible nor valuable, but they continue to attempt to fit in with the crowd. This supports Reid-Searl’s (2008) findings regarding medication administration by nursing students whose actions during workplace experiences were often motivated by attempts to please the RN they were working with, to avoid conflict

and to fit in with the culture, even if the action meant contravening what they knew to be evidenced based right actions. Students believed if they did not comply they were at risk of poor marks or failure and that fitting in increased employment opportunities and avoided feeling like the outsider (Reid-Searl, 2008). When combined with criticisms of their education, ECRNs' experience and knowledge are further devalued and calls their ability to work effectively as RNs into question. ECRNs commented on many occasions that it would not have mattered how many workplace experiences they completed as students, they could not have understood the role of RN until they experienced it. I would argue that ECRNs' stories demonstrated an institutional divide between the universities providing nurse education and the health care settings where ECRNs undertake workplace experiences. This divide challenges the concept and application of lifelong learning expected of nursing graduates.

Regardless of the context, adult learners are mature, socially responsible individuals who participate in sustained informal or formal activities that lead them to acquire new knowledge, skills, or values; elaborate on existing knowledge, skills, or values; revise their fundamental beliefs and assumptions; or change the way they see some aspect of themselves or the world around them (Cranton, 2016, p. 3).

All the participants in this study were adults learning about how to work in a profession that exists within a social context. There is, however, continuing controversy about whether learning is connected and relational or independent and autonomous. The perspective taken has implications for where the responsibility of learning lies. In traditional western societies individualism is the valued norm (Brookfield, 2005) and workplace learning tends to focus on individuals learning to work with others, rather than learning to work in relation to others (Cranton, 2016). For the ECRNs this individualism

existed in their workplaces where learning took a subject to object (Habermas, 1989) approach.

Senior RNs, supervisors or educators were the possessors and deliverers of information, and it was they who decided on the learning needs of the ECRN or nursing student. The ability to understand information and apply it to their practice was the responsibility of the ECRN. When unable to understand the information provided or apply it to their practice ECRNs were held responsible and viewed as unable to 'hit the ground running.' Freire (2000) refers to this as the 'banking' concept of education which can lead to learner oppression as they are viewed as passive recipients of information without the need for creativity or criticality of thought. In the banking approach, learners depend on receiving knowledge and are dependent on those who provide and possess it. An alternate view of adult education is when adults engage in relationships that help them to develop the confidence to discover, define and explore problems as they arise; this is about developing the processes of learning which as Jarvis (2006) reminds us are rarely recognised. As Freire suggests

Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world and with each other (Freire, 2000, p. 72).

Transformation resulting in learning happens within the individual but as Merriam and Bierema (2014) remind us learning takes place in a context that is social. In transformative learning, awareness of context is a core element (Illeris, 2014b) but the processes leading to transformation, transcend context (Taylor & Jarecke, 2009).

Participants, like most adults had many varied roles and responsibilities, of which being a learner was one (Merriam & Bierema, 2014). All roles impact on each other and are part of what it is to be human. ECRNs were parents, children, friends, students, partners, nurses, members of professional organizations and so on. The ECRNs' stories demonstrated the social and relational nature of learning, where people learn from, with and about each other.

Theme: Altruistic Intent

The story of Ezri: a parable (continued)

Over time the faces and the voices of others were becoming clearer and he listened to their stories filled with their pain and joy until eventually their faces became apparent and he knew then they were humans like him. In seeing others and hearing their stories, Ezri began to know how he could help and this brought comfort.

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In this study, the reasons ECRNs stayed in the profession closely aligned with their reasons for deciding to become a nurse in the first place. Participants spoke of their desire to make a difference in the lives of others and to give something back to society and felt nursing would offer the opportunity to do this. They discovered that while trying to meet the perceived and unfounded expectations of others, those they were meant to care for were not at the centre of care and ECRNs lost sight of the reason they decided to become nurses. The decision to stay was directed by the ECRNs reformulating and

reconnecting with their reason for becoming a nurse and learning about how their work as a nurse could enable them to fulfil what I have termed their altruistic intent.

During interviews, ECRNs were asked directly, 'Why do you stay in nursing?' While the responses to questions about 'How do you stay?' were influenced by internal and external factors, the reasons as to why they stayed were very personal and related to their values and desires to do something for others. Although ECRNs did not use the term 'altruism' or 'altruistic,' their explanations for why they stayed aligned with this concept. Practical reasons for working, such as financial responsibilities were mentioned and are important to live in society, but in all cases, ECRN responses regarding why they stay, transcended the technical and practical reasons for staying.

Altruism in nursing has been associated with notions of love, compassion and responsibility and an unspoken expectation to take care of another human with a genuine desire to alleviate another's suffering (Eley, Eley, & Rogers-Clark, 2010; Slettmyr, Schandl, & Arman, 2017). These are concepts founded on the belief, that one life or being is no more or less valuable than another (Post, 2007). Historically, nursing was closely aligned with altruism due to its vocational status. The vocational nature and altruistic foundations of the profession have become associated with terms such as subservience, obedience and sacrifice (Eley et al., 2010). Slettmyr et al. (2017) propose that in modern society these expressions are in opposition to the concept of professionalism and paid employment which resonate with Carter's (2014) earlier findings that nurses were hesitant to claim their acts at work as altruistic. Eley et al. (2010) argue that altruistic traits are necessary for the professional nurse and in fact in the United States of America

(USA) education providers offering pre-registration nursing programs must show that graduates can demonstrate altruism through behavioural actions, understanding of cultures and beliefs and valuing the perspectives of others through a commitment to advocacy and mentoring colleagues (Milton, 2012).

ECRNs' reasons for staying aligned with the way altruism is conceptualised in modern society which suggests that it is related to the intent behind the action. The debate about what constitutes altruism is ongoing, particularly the question as to whether altruism exists where a person who provides an act benefits from that act. Altruism, also referred to as prosocial behaviours (Carlson & Zaki, 2018) has been divided into *other-orientated* behaviours (altruism) and *self-oriented* behaviours (egoistic) (Carlson & Zaki, 2018) where the *other*, as in earlier discussion, refers to the being apart from the self. In 1785 Kant proposed that when someone benefits from prosocial behaviour, then the act cannot be considered altruistic but is egoistic and impure (Carlson & Zaki, 2018). Slettmyr et al. (2017) found nurses refused to engage in altruistic acts with another if such acts did not result in reciprocity, referring to this as 'conditional altruism'. In this study, while some ECRNs spoke of how they initially expected gratitude from those they worked with in the health care system, it was becoming conscious of this expectation for reciprocity that allowed them to be emancipated from it and reconnect with their reasons for nursing and why they stayed. More modern views of altruism propose that where a benefit results from a prosocial act but where that benefit was not the intended outcome of the act, then the act can be considered altruistic (Batson, 1987; Carlson & Zaki, 2018). From this viewpoint, the decision of what is or is not altruistic relates to the intention of and motivation for the act toward *the other* (Batson, 1987; Carlson & Zaki, 2018). Lay

perceptions of altruism in modern society relate to a person's motivation and 'true altruism can involve benefitting both oneself and others, so long as one's motive is other-oriented' (Carlson & Zaki, 2018, p. 37). The gain spoken of by ECRNs was emotional and incidental rather than expected; feeling good in response to assisting others. Carlson and Zaki (2018) found that feeling good in response to helping others was associated with genuine altruism, supporting the notion that altruism is a socially and culturally constructed concept where the meaning applied to it is dependent upon the context and the time in which it is used and by whom.

The desire by ECRNs to make a difference grew as they explored their disorientation and came to realise the act of 'giving back' involved more than mechanical behaviourist acts; it was about being with people. By becoming conscious and moving beyond the need to please others, ECRNs were becoming emancipated from the constraints that had moved their focus from the *other* and stopped them hearing and becoming a part of those stories. Through the emancipation from false assumptions, ECRNs were learning about themselves, moving toward their authenticity and in so doing valuing the authenticity of others. As Milton (2012) suggests, altruism is about humanness and acknowledging others so that authenticity emerges as people develop a higher and more accurate understanding of their own.

Like their nursing role, the altruistic intent of the ECRNs was broader and more profound than behaviourist acts. Altruistic intent was about the ontology of the ECRN and accepting and valuing the diversity that comes through knowing the authentic self and being with people and

a personal commitment to an ontological philosophy of professional nurse practice incarnated with reverence and awe for what it means to be human (Milton, 2012, p. 224).

The Lion, The Witch and Wardrobe is a novel written for children by CS Lewis (1950). The allegorical story is one of fantasy, rich with metaphor and pathos where the lion king, Aslan, knows the 'deep' magic which transcends time and human reason. In the story, a battle is fought and Lucy, a young girl and the protagonist, is gifted a magic healing cordial. When her treacherous brother Edmund, is wounded, Lucy is reminded by Aslan that she possesses the cordial. Distraught at her brother's condition, Lucy administers it.

Her hands trembled so much that she could hardly undo the stopper, but she managed it in the end and poured a few drops into her brother's mouth. "There are other people wounded," said Aslan while she was still looking eagerly into Edmund's pale face and wondering if the cordial would have any result. "Yes, I know," said Lucy crossly. "Wait a minute." "Daughter of Eve," said Aslan in a graver voice, "others also are at the point of death. Must more people die for Edmund?" (Lewis, 1950, p. 164).

Lucy is reminded that altruistic acts are not based on personal gain but about intention and about how such acts are distributed. ECRNs faced the dilemma of not being able to nurse in the way they had imagined due to fiscal and staff constraints within the system, but also their preconceptions of the role and their personal needs. This is not dissimilar to the constraints faced by Lucy. Coming to terms with and deciding how to allocate and prioritise care was an essential part of Lucy's learning. Through an intersubjective relationship, Aslan helped to reorient Lucy's perspective, causing her to question her

intent and place others' needs above her own need to only focus on her brother. The participants in this study came to realise that making and prioritising decisions did not mean negating or neglecting care but instead, was a way in which the ontology of altruism could manifest in their practice and through intersubjective relationships. Working in fiscally driven healthcare systems (Duckett & Willcox, 2015; WHO, 2017), with finite resources (Baum, Freeman, Sanders, Labonté, Lawless, & Javanparast, 2016; Eckermann, Lynnaire, & Ivers, 2016; WHO, 2017) is a reality in our society. The transformation of participants' perspectives resulted in them coming to understand that prioritising the delivery of care is an element of altruistic intent by the sharing of resources including time. This perspective does not deny the needs of all, nor the need for nurses to advocate as part of altruistic intent and ensure resources are available and accessible but it does recognise the developing expertise required to make sound decisions developed through experience, critical reflection dialogue and confidence. As participants spoke of their disorienting dilemmas and perspective transformation, they were able to move toward authentic ways of working and being, aligning their expectations with the requirements of the profession and meeting their desire to make a difference.

The transformations experienced by participants resulted in them coming to new understandings about what they needed to do to 'make the job work for them' which was not about right or wrong but rather perspective. Participants spoke of the way they benefitted emotionally from their interactions with patients, clients and families and while initially for some, gratitude was expected, by becoming wakeful to this their perspectives were transformed, and reciprocity was not the expectation but an added benefit when and if it was offered.

The benefits received as a result of their work as an RN were not related to remuneration, but to the value they discovered in the human connection when working and being with people including patients, clients, colleagues and students. Through their altruistic intentions, experiences, critical reflection and discourse, participants were able to begin to embody and enact altruism, incorporating it realistically into their ontology and their identity supporting Milton's (2012) claims that altruism is not a behavioural process but manifests through attitudes and then acts. The transformation of perspectives resulted in welcome outcomes for participants helping them to identify the purpose in their work and focus and reconnect with the reasons for commencing and continuing to work as nurses.

Theme: Human Connection

The story of Ezri: a parable (continued)

As Ezri told his story about letting go of expectations, Alfrida's face also became clear to him and he could now see she too was human. One day she asked him, 'Why do you stay?'. Ezri smiled and in a voice infused with hope said simply, 'For the same reason I came'.

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ECRNs identified the importance of human connection, and this is, in fact, the picture created by the threads in this thesis. Participants were drawn to the profession because of relationships with others. The stories of the ERCNs demonstrated the way that human connection drew them into the profession, led them to the edge of their experience,

helped them to move through their disorienting dilemmas and was ultimately the reason why they stayed.

Coming to this view is emancipatory, moving the focus from the 'doing to' to the 'being with'. By freeing the mind of thinking only about the next task, allows the nurse to be with another human in the moment (Hills & Watson, 2011). This connection is important for all relationships in the workplace. By learning and experiencing the power of intersubjective relationships in their lives, ECRNs could apply this in their work life, demonstrating the importance and power of experience and knowing oneself as a way of knowing others, connected through their humanness. As ECRNs awakened to the unrealistic expectations placed upon them, they also became aware of the expectation they placed upon *others*. The altered perspective made visible the interstice or seams between lifeworlds where dialogue could occur, and the *other* could be seen as a person rather than an object.

When nurses, including supervisors and colleagues treat each other as objects they are more likely to treat everyone as objects including those for whom they care (Hills & Watson, 2011). This is not unheard of in nursing students as Benner et al. (2010) found with senior nursing students who were initially preoccupied with technical interventions, treating the patient as an object of care rather than as a person. Freeing themselves from focussing only on the technical constraints, ECRNs could see and be with people regardless of who that person was, colleague, peer, supervisor or those they were supervising; tasks became about being and doing with, rather than doing to, embedded in the broader context of the whole person and their lifeworld. This shift meant ECRNs

were moving beyond 'playing' the role of the nurse to living it, as it transformed and became enmeshed with their identity and part of their ontology. There was an understanding that human connection and the centrality of relationships was realised by reflecting on their own experiences and this occurred most effectively through human connection. By doing this, they could identify the way experiences connected to moments of *being with the other*; the transformed pre-nursing frames of reference about why they started nursing, connected to the reasons for why they stayed. In this way, participants were linked to moments through their past, helping them to make and value human connections in their present and plan for ways of managing disorientation in their future.

Conclusion

This chapter examined the themes of the stories of the ECRNs in this study. The themes form the fabric of the thesis woven from the threads of those stories. It is a story of human connection acknowledging that nursing is a relational profession and reflects the broader intersubjective nature of being human. Intersubjective relationships are a way of knowing about self and others by sharing safe spaces where dialogue, critical reflection and transformation of perspectives can begin to happen. As shown in this chapter through the ECRN stories, human relationships and the associated expectations led to disorienting dilemmas but it was also relationships that helped ECRNs to move through them. Disorienting dilemmas are inevitable, it is a way in which we learn, but it is how people approach them that impacts on the outcome. Developing and embedding supportive processes within pre and post learning environments that acknowledge the continuity of learning can help support ECRNs as they are led to the edge of their experience and move toward authentic ways of being. The final chapter will offer

recommendations based on the themes discussed in this chapter and focus on the importance of becoming conscious of disorienting dilemmas and developing processes that allow ECRNs to move through and learn from them.

Chapter Eight. Conclusion, implications and recommendations

In this study, I have used TLT and a narrative approach to investigate the question, *ECRNs: how and why do they stay?*, exploring their disorienting dilemmas and examining how they, as individuals worked through and learned from them. In the first five years following registration as an RN, ECRNs are at increased risk of leaving the profession shown in studies regarding the intent to leave (for example, Benner et al., 2010; Crow et al., 2005; Rafferty & Clarke, 2009; Rudman et al., 2014). This highlights the need for research into how and why they stay, to consider strategies to help retain ECRNs in the future, capture their experience and meet the increasing demand for RNs now and in the future. No research could be identified into the questions posed using a transformative learning theory framework. The themes drawn from the results of this study and discussed in Chapter Seven, included the challenges to identity resulting in disorienting dilemmas; the importance of intersubjective relationships and becoming authentic and; altruistic intent and the value of human connection. These themes have implications for pre and post-registration education for ECRNs and nursing students, RNs working with, supervising and educating ECRNs and those regulating and developing policies that guide and direct ECRN learning across educational and health care settings. The findings call into question the approaches and attitudes toward learning in pre and post-registration periods for future cohorts of nursing students and ECRNs in Australia. This study adds new knowledge to the area of nursing while providing ECRNs with a vehicle through which their voices could be heard.

This chapter will summarise the purpose and aim of the study, discussing the implications of the results, making recommendations for learning, education and policy development of ECRNs and point toward areas for future research. Limitations of the study are also discussed.

Implications of the findings.

The stories revealed a dissonance between what ECRNs imagined it would be like to be a nurse and what they subsequently experienced working as RNs. Becoming conscious of their disorienting dilemmas was the first step for ECRNs toward transforming their perspectives. Participation in dialogue with trusted others enabled ECRNs to critically reflect on the premise of their disorientation and move toward perspective transformation and authenticity. While often difficult to encounter and work through, disorienting dilemmas presented opportunities for growth and adaption through transformative learning. Critical reflection and dialogue were facilitated through intersubjective relationships and implied the need for skilled and cross-contextual facilitators for ECRNs, commencing at pre-registration education.

It is expected that RNs will be lifelong learners (Davis, Taylor, & Reyes, 2014; Esplen, Wong, Green, Richards, & Li, 2018). In Australia, this is made explicit in the registered nurse standards for practice (NMBA, 2016c) and implied in the NMBA's (2016d) continuing professional development requirements needed to qualify for continuing registration as an RN. Awareness and implementation of sustainable learning processes that provide continuity and stability at times of disorientation and beyond are required

to ensure lifelong learning philosophies are not only adopted in educational contexts but planned and applied, rather than left to chance (Cranton, 2016; Taylor & Jarecke, 2009) as was the case for the ECRNs in this study. Disregarding and devaluing ECRNs' experiences by those in the workplace and the imposition of unfounded expectations demonstrates a lack of understanding from those working with, supervising, educating and employing ECRNs. It implies a lack of awareness and value regarding adult and lifelong learning principles and the aims of pre-registration education. Working from the premise that formal education is an end in itself, with the expectation that it will 'produce' nurses who were ready to hit the ground running (El Haddad et al., 2013), placed ECRNs in positions where they were unable to meet external and self-imposed expectations. This approach leads to an institutional divide, stifling the nature and continuity of adult learning. Such ideology denies that learning happens to the whole person, everywhere and anywhere across settings, contexts and lives and is a continual process.

While lifelong learning approaches suggest autonomy of the learner (Jarvis, 2006), this does not imply that learners are left alone to figure everything out or to prove themselves to others as was identifiable in the stories of the ECRNs. The results of this study reinforced the importance of relational and transformative learning for ECRNs as they learned about living the RN role from and with others. These findings have implications for educators and academics across educational and health care contexts when thinking about how ECRNs learn, what is expected of them and the centrality of relationships to learning processes as discussed in Chapter Seven. The results of this study lead to questions about current curriculums and workplace strategies and their efficacy in

supporting ECRNs' develop sustainable lifelong learning processes. ECRNs stories revealed disorienting dilemmas during times of major transition for example from nursing student to ECRN and in most cases they were left to navigate their way through their disorientation. This leads to a second impact from this research which revolves around expectations placed on ECRNs as they commence working as RNs for the first time. If regulatory authorities expect RNs to be lifelong learners, it is unreasonable to expect that the learning associated with becoming an RN will be confined to formal pre-registration education that focusses on learning skills and relies on imagination to consider how they will live as an RN. The stories confirm that disorienting dilemmas are a part of the adult learning process and this is supported by the literature about transformative learning (Illeris, 2014b; Mezirow, 1991). ECRNs face transitional upheaval and disorienting dilemmas as they begin to learn what it is to live as an RN and in considering how to incorporate that role into their developing identity. Answering questions such as these requires further investigation about how learning for ECRNs is developed, delivered and viewed by those who work with, educate, supervise and support ECRNs and those who influence learning policy.

How ECRNs stayed working as nurses, centred on intersubjective relationships that were based on trust, respect and honesty in a space where judgment was suspended. Such relationships enabled ECRNs to engage in dialogue and critical reflection helping them begin to make sense of their experiences, transform their frames of reference and as the ECRNs suggested, make the job work for them. These types of relationships have implications for the way learning is viewed and constructed in pre and post-registration settings including ways that ECRNs can be assisted to identify and work through

disorienting dilemmas and experience continuity of learning that will bridge the divide between university and the workplace and help them develop ways to bridge transitions throughout their careers.

Relational learning means learning with, from and about others and in this study was central to perspective transformation. The findings highlight and reinforce the concept that transitions are more complex than the application of skills and knowledge. Learning and thus transitions happen to the whole person, impacting their identity. This complexity is part of the developing ontology as ECRNs move toward authentic ways of being; learning to live the role of RN rather than play at it (Jarvis, 2006; 2014) but to do this the workplace must be established as a central place of continuing learning for ECRNs. ECRNs must be offered the opportunity to situate the skills learned in pre-registration education within the health care setting but in the broader context of learning how to live the role of RN as they discover who they are becoming as people through relational learning; it is this type of learning that should be valued as central to the ECRN period.

The reasons why ECRNs stayed working as nurses, aligned closely with the reasons that drew them to nursing in the first place; altruistic intent. The ECRNs stories demonstrated that in order to stay, a transformation of their perspectives was required to free them from unachievable and unfounded expectations imposed by self and others, realigning their imagined ways of being with their growing breadth and depth of experience. It was through critical reflection that ECRNs could examine situations from different angles and consider different perspectives. When facilitated through intersubjective relationships,

ECRNs were able to move forward in their nursing trajectory and discover ways to reconnect with and fulfil their altruistic intent, through person-centeredness which led them to appreciate and value the importance of human connection. This finding has important implications for nurse educators and academics in developing ways to help ECRNs face their disorienting dilemmas and realign their frames of reference by debunking assumptions and enabling the development of realistic goals and reconnection with the motivating factors that brought them to nursing.

In this study, ECRNs explained how and why they stayed and through their stories it became apparent that disorienting dilemmas will and do occur and should not be denied. Disorienting dilemmas present a signal and offer an opportunity, to become wakeful to and question assumptions and the need to realign frames of reference. Assisting this process must be a shared responsibility between education providers and workplaces; as there is no prize in learning alone and the stories in this study attest to the concept that learning is contextual and relational with many of the ECRNs describing disorienting dilemmas born from witnessing or experiencing the unprofessional behaviours of senior colleagues, supervisors and managers. Darbyshire, Thompson & Watson (2019) propose that stories of unprofessional behaviour and a culture of bullying has been with nursing for over 40 years. Whilst Edmonson, Bolick and Lee (2017) suggest that the issue has moved to the forefront of conversations; strong and principled action must be enacted to enable the timely removal of the bully from the workplace rather the bullied (Darbyshire et al, 2019). Professional, educational and government bodies with responsibility to educate, regulate and employ ECRNs must acknowledge the shared responsibility for helping to develop, structure and implement the processes that support

ECRNs in their work including the rejection of bullying and unprofessional behaviours. There is also a need for positive approaches that develop strong bridges and skilled navigation such as that seen in Magnet Hospitals to help ECRNs cross safely as they learn who they are becoming as RNs and as people providing environments where they can learn and grow rather than having to cower and consider leaving. Lifelong learning processes introduced at the commencement of nursing education, present ways to sustain ECRNs throughout their careers. This approach does not imply prescriptive measures to learning but rather acknowledges that relational and transformative learning is central to adult learning.

Recommendations

The recommendations in this chapter draw directly from the findings discussed in Chapters Six and Seven as well as the implications highlighted earlier in this chapter. The transformative learning lens employing qualitative research principles and narrative methodology was used to conduct the study and guides the approaches described in the recommendations.

Recommendation 1: Becoming conscious of disorienting dilemmas.

It is recommended that skilful individual facilitation is included in the education of students and ECRNs to help them become conscious of disorienting dilemmas, acknowledging their occurrence as part of lifelong learning and identity development. This facilitation should commence with formal pre-registration education and continue as ECRNs transition to the workplace and the RN role, helping them to prepare for subsequent life transitions and disorienting dilemmas.

Relational learning must commence at pre-registration education. Through the intersubjective relationships with skilful facilitators and emancipation from unrealistic expectations of self and others, ECRNs in this study were learning to take responsibility for their decisions and moving toward authentic ways of being. Early in pre-registration programs, educators and RNs working with nursing students must begin to bring into consciousness the broad concept of disorienting dilemmas, normalising them whilst acknowledging the difficulty that may occur in facing them and supporting students and ECRNs with processes to address them. The introduction of such processes presents students with the opportunity to test, develop, practise and apply transformative processes. This would involve dialogue and critical reflection on experience and applying these approaches to real life dilemmas using for example, methods such as clinical supervision or mentorship. In this way the processes for learning from disorienting dilemmas would gradually become part of the ontology of the individual, transcending particular contexts whilst remaining situationally transferrable and relevant.

ECRNs in this study looked for facilitators who were familiar and in whom they had developed trust. Through relationship and dialogue, it was those people that assisted ECRNs to critically reflect on and make meaning from their experiences, considering other ways to think about things. This approach would require bipartisan support, between educational and health care organizations. Shared policy, curriculum development and personnel across health and education settings would facilitate the development of mutual understandings and enable the application of structured and continuing learning

approaches for nurses as they move from university to the workplace, serving to highlight the value of lifelong and relational learning and apply it to practice.

Recommendation 2: Supporting the facilitation of ECRNs (and student nurses) learning journeys through intersubjective relationships and maintenance of safe workplace environments.

The development of new nurses must be a shared responsibility between educational institutions, professional and regulatory bodies and the health care setting. RNs across contexts and levels must be supported to work with ECRNs. Increased awareness and understanding of the disorienting dilemmas faced by ECRNs, the processes available to help work through them and the aims of pre-registration education would be a firm place to start. Formal education regarding engagement in intersubjective relationships, dialogue and critical reflection must be available to RNs working with ECRNs so they can learn how best to facilitate critical reflection and transformative learning. The expected allocation of quarantined time for RNs would enable them to engage in the processes of formal supervision; their own and that of ECRNs. Value for undertaking such roles must be supported by those at all levels of the health care system, professional organizations and regulatory bodies, applied through policy, funding, formal role descriptions and access to ongoing education. Formal structuring of the role and remuneration would acknowledge the value attached to the position and to those who perform it. Such champions would be expected to help facilitate a culture that rejected unprofessional and bullying behaviour, combined with the development and application of high level policy, codes of conduct and strong pathways that action against, reject and expect

mandatory reporting of unprofessional behaviours and where pathways to the removal of bullies are explicated and enforced.

Recommendation 3: Formal supervised practice period and transitional registration.

It is recommended that a supervised period of transitional registration is introduced and funded, immediately following the completion of the pre-registration qualification and movement into the workforce. This would require a structured and shared curriculum between the education provider and health care organization to bridge the transition. Learning would focus on the development of intersubjective relationships and transformative learning approaches and assisting ECRNs develop accurate frames of reference and living the role of RN.

Programs that build directly on from undergraduate education curriculums would provide ECRNs with familiar processes learned and practised throughout pre-registration education and based on the application of lifelong learning principles. The introduction of formal transition programs would acknowledge entry to the workforce as a significant and intensive learning period requiring skilled intersubjective support. Partnerships between nursing student educators and employers of ECRNs in the development and delivery of learning programs would assist in establishing shared understandings and procedural continuity.

The focus for this period would be the adjustment to the workplace and the developing identity of the ECRN as they start to learn what it is to live the RN role. Intersubjective

relationships using models such as clinical supervision or mentorship would be central in assisting ECRNs to reflect on assumptions, align their frames of reference and make meaning of their experience. This approach recognises that commencing work in a new role concerns the developing identity and ontology of the ECRN focussing on more than the acquisition and application of skills and knowledge. The nursing profession as a whole must acknowledge that making sense of experiences is a significant element of learning how to be a nurse and who the nurse is; this is essential in learning how to work as a nurse.

Recommendation 4: Including nursing students as integral members of the health care team.

It is recommended that students are included as active members of the health care team with formal roles and responsibilities, actively working toward patient centred goals while learning about, from, and with people. ECRNs in this study, described situations where as students they excluded as members of the health care team and as they commenced work as RNs, felt compelled to try and fit into new roles and workplaces. Having students work in health care teams involved in real-life projects with a patient centred and community engagement focus and with defined role descriptions and responsibilities, would provide nursing students with a purpose and tangible outcomes. It offers an opportunity to connect with altruistic reasons for entering the profession. Linking student project involvement to formal assessments that examine working relationships as well as project methods and outcomes would provide another avenue to be explored. Approaches such as this would place students and ECRNs in contact with each other and

more experienced RNs, offering opportunities to develop informal intersubjective relationships, where learning can occur.

Legitimising inclusion in the health care team with a named role offers students and ECRNs the opportunity to broaden and deepen their understanding of how and where nursing happens, what nurses do and how the healthcare system works. In Australia, the RN role incorporates more than direct patient care but is always person-centred. The RN standards for practice in Australia state that

...practice includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills (NMBA, 2016, p. 2).

Being in a role that adds to practice and person-centred care will foster interactions between nursing students and RNs from a diverse range of areas and breadth of roles. It provides a place where dialogue in and about the RN role can occur as well as provide opportunities for growing networks for peer learning. As members of the health care team, nursing students and ECRNs must be encouraged to learn about and discuss the expectations of the role. Creating situations where students and ECRNs work together on projects with more experienced RNs, offers the potential to identify and acknowledge students and ECRNs as human with prior life and educational experiences that can be drawn upon and contribute to person-centred care.

Directions for future research, investigation and education

This thesis sought to investigate *how and why ECRNs stay* working in the profession by exploring their disorienting dilemmas. The findings raise many questions and identify signposts toward future research, investigation and education. Professional and regulatory bodies must be alert to and conscious of the disorienting dilemmas faced by the profession by examining the assumptions that impact on how ECRNs are viewed and supported in the workplace and this thesis provides evidence regarding this. The recommendations suggest ways of incorporating relational and transformative learning across contexts, aiming to improve the transitional experiences of ECRNs and the support available to navigate the disorienting dilemmas faced. High priority must be given to the learning of ECRNs in the workplace as they try to make sense of their experience as RNs. Exploring ways to bridge the institutional learning divide through shared vision and responsibility is worthy of further investigation and discovering ways to ensure lifelong learning is a practical and applied reality rather than a token phrase. Supporting ECRNs with processes to help them make sense of their experiences that emancipate them from unrealistic expectations will allow them the opportunity to make informed decisions about their continued employment as RNs.

Trialling the inclusion of nursing students as dedicated members of health care teams, a supervised practice period with transitional registration for ECRNs are areas worthy of further investigation and discussion to help further explore the question of how and why ECRNs remain working and to assist in developing further strategies to improve the retention of RNs and harness their growing experience. Exploring the development of nursing curriculums that focus on relational and transformative learning by bridging the

organizational and transitional divide would benefit from further investigation and discussion.

Studies that follow Australian ECRNs from the beginning of their careers, such as the study conducted by Rudman et al., (2014) would be helpful in providing further evidence regarding ECRNs' intent to leave during the first five years of practice. It would be useful to extend this research beyond the first five years to determine if ECRNs remain working as nurses beyond this period, the paths they take and how and why they continue to stay. Perspectives might be widened by interviewing educators and those who work with, employ and supervise ECRNs to examine a variety of perspectives regarding the issue of ECRNs: how and why they stay.

The topic would benefit from further research, using similar philosophical and methodological approaches to investigate the experiences of ECRNs in other regions, particularly in comparing those who share similar educational and regulatory approaches to nursing as are found in Australia. This may support and broaden the findings in this study.

Finally, there is a lack of empirical evidence regarding the attrition rates of RNs during the first five years of practice. Whilst accessing and collecting such data would prove difficult, it would add support to claims that there is a high attrition rate for this cohort. This information would also contribute another dimension and point of comparison to the existing research surrounding intent to leave.

Limitations of this thesis

A thesis must have limitations otherwise where would it begin and end and this thesis is no different. Firstly, the research was limited to the exploration of the given questions in this study, how and why ECRNs stay by listening to the stories of ECRNs. Secondly, the investigation was limited to a particular philosophical perspective and research methodology influencing the way information was collected, analysed and reported. Stories were viewed through the philosophical framework of transformative learning theory which in turn limited the threads and themes identified to reflect the framework. This was however in keeping with the philosophical framework and its constructivist underpinnings where there is no one truth and thus interpretations may differ. Other methodologies and philosophical approaches may result in the identification of different threads, themes and recommendations. Thirdly, the voluntary nature of participation may have attracted a certain type of ECRN who was motivated and confident enough to tell their story. Finally, participant recruitment was confined to ECRNs working in Australia. This limitation was imposed based on my interest in the Australian nursing workforce. Further studies that expand on this limitation would help illuminate a broader picture to see if ECRNs from other countries provide similar reasons for how and why they stay.

Personal reflection

Undertaking this study has been an amazing trip. Sharing the stories and listening to the experiences of ECRNs was a privilege and I am humbled by their willingness to be a part of this research. The stories I have heard have become a part of my own story, and I am

bound to treat them with care and reverence and to share those stories with others in a respectful way. Being a researcher is not about me, it is not being the hero or extraordinary, it is about sharing the findings that might make a difference for participants and future ECRNs. Honouring their gift of participation was a significant responsibility and meant always attempting to *get it right*. Working and studying in the adult education space provided me with some knowledge of how adults learn, but the opportunity to undertake this research taught me so much more, reminding me that lifelong learning is a journey that continues, occurs anywhere and everywhere and happens to the whole person, impacting their continually developing identity. I am always amazed at how the more I learn, the more I see there is to learn, and emancipation is offered in the knowledge that we cannot know everything, but can develop ways to learn and think about things; as Newman (1989) wrote, 'to live is to change, and to be perfect is to have changed often' (p. 41).

As I spoke with participants, I learned to be mindful of the questions asked and the way in which they were asked but more importantly to listen to the responses; this was about their stories. I sought not to speak for ECRNs but rather provide the medium by which their voices could be heard. ECRNs who participated in this study seemed to value this opportunity as often they had experienced situations where they were muted or their voices not heard; this study gave them the chance to speak and be heard.

Sharing the stories of others has opened my eyes in many ways, particularly to the complexities faced by ECRNs as they learn about the RN role and how it impacts their identity. It has helped to highlight the need to move beyond assumptions about why and

how ECRNs stay. By identifying the richness and fullness that comes from telling, listening to and writing the story, the need for lifelong learning processes and the centrality of intersubjective relationships has become more evident as a shared need. Discovering authentic ways of being required ECRNs in this study to find their humanness by becoming emancipated from imposed and unfounded expectations which in turn allowed them to experience and learn the importance and value of human connection.

To conclude, I have faced many disorienting dilemmas in my work life, student life and personal life during the researching and writing of this thesis. Seeing a way forward often meant challenging the assumptions I held and transforming my perspectives. In narrative approaches to research, the researcher becomes a co-constructor and therefore a part of the research story; they stand in the landscape (Bruner, 2004; Clandinin, 2007). The length and depth of this journey has allowed me to experience the intertwining of stories in the interstices where humanity exists. I do inhabit the landscape of transformative learning, learning much about myself as well as learning from, with and about others and like the ECRNs, forming a more profound and broader understanding about and through the gift of human connection. This marks the end of my thesis but the beginning of my research journey and I look forward to the learning that is yet to come.

Epilogue

The story of Ezri: A parable

It was beyond dark - black as pitch. Darker he thought than blindness and like nothing else he had ever experienced. He could see nothing... nothing. Vision was impossible. It was

cold but still and there was a smell of dampness ... hanging. There was a sense of something, of what? The waiting and the blindness heightened the sense expectancy. Or was that fear? He could still hear a low murmur, building ... building to an intense hum almost like chanting, like a swarm of wasps in the distance, but this was close. He didn't want to reach out, he didn't want to move, if he stood still he would be safe, unnoticed. And if he did stretch out, who knows what he might touch. But in the blackness, in his blindness he felt his balance compromised and had to use his arms for balance. A voice in his head told him to be calm but his heart raced.

Ezri had read about this place and spoken to many others about it. They had talked in depth about what it was like to be there, the way they felt, the sense of unknowing, the insecurity. He thought he knew it and that the conversations he had engaged in and the reading he had done had prepared him. He had chosen to come. He thought he had been ready but, in that moment, lost to time, he had no idea what might happen next. As light slowly began to infiltrate the darkness and his pupils began to accommodate, unblinking he looked and stared and realized nothing had prepared him for this.

In the half light, nothing was clear, everything seemed faded and merged. There was movement but he could not tell what it was that was moving and the hum had become less

*like wasps and more like a cacophony of voices that was
indecipherable.*

*He was frightened, moving more and more quickly as
ghostly images sped toward him. He dodged from side to
side trying to get out of their way, whatever they were – it
all felt out of control and his brain buzzed adding to the
background voices that held no meaning.*

*From behind him a voice, brusque, not angry but as clear as
any he had ever heard asked, ‘what are you? who are you?
why are you here?’ He spun around not knowing if he
should answer. The voice came from a shape in front of him
which was also a blur but unlike the others was still.*

*My name is Ezri he said. I came to help. And explained how
he would do that and his expectations in coming. He said
‘but I can’t see or hear anything clearly. Everything is in
shadows’*

‘But I can see you and hear you’ the voice said.

‘But who are you?’ Ezri asked

‘My name is Alfrida.’

*As time passed Ezri began to decipher some of the voices
and the instructions hidden in the hum. He tried to do what
they told him, thinking that this would help, but he was
unsure.*

Every few days Alfrida would come and sit with him and ask him questions about his experiences in this place. He spoke to her about how hard it was to be in a world of shadows.

One day staring down he admitted to feeling helpless and said to Alfrida 'this is not what I expected, my ideas are not true. I must forget them'

Alfrida asked 'Why must you forget? You have the skills and the knowledge but who are you and who are you becoming?' Ezri thought these strange questions; he had told her who he was and why he was there.

Over time Ezri continued to speak with Alfrida, constantly questioning the wisdom of his decision to come to this place, wondering if there was a point to it. The more he thought and talked about this and continued to do what he was told, the more he was coming to see that he was not helping in the ways he had imagined and perhaps needed to give up and go back. But he also came to realise that he was beginning to see Alfrida more clearly.

Ezri continued to work and the work was challenging but he thought often about the questions Alfrida had asked and who he was becoming. Ezri began to understand that he was letting go of who he thought he would be and how things would be, focusing instead on what was actually happening. He still listened to the commands of the voices

*but before he acted he thought about what he had learnt
and what he was learning now...*

*Over time the faces and the voices of others were becoming
clearer and he listened to their stories that were filled with
pain and joy until eventually their faces became apparent
and he knew then they were humans like him. In seeing
others and hearing their stories, Ezri began to know how he
could help and this brought comfort.*

*As Ezri told his story about letting go of expectations,
Alfrida's face also became clear to him and he could now
see she too was human. One day she asked him, 'why do
you stay?' Ezri smiled and in a voice infused with hope said
simply, 'For the same reason I came'.*

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Appendices

Appendix 1: Invitation to participate

RESEARCH STUDY

Early Career Registered Nurses: How and why do they stay?

Invitation to Participate

This research aims to investigate significant events (disorienting dilemmas) identified by early career registered nurses (RN). Participants will have been:

- Registered with AHPRA as a nurse for at least one year and no more than five years (inclusive)
- Working as an RN in Australia (inclusive) in one (or a combination) of the following areas:
 - mental health setting
 - acute care setting (including critical care)
 - community health care setting
 - aged care setting.

The study explores the way early career registered nurses approach and deal with significant events that they experience in the clinical setting and the impact these have upon their decision to remain within the profession. Ethics approval has been granted from the University of Wollongong for this study (HE14/060).

It is proposed that investigation into the ways early career RNs approach and react to significant events can guide development of strategies that can assist in the retention of RNs within the profession

This research will investigate:

- The context in which participants work.
- The expectations and assumptions that participants held when they commenced their nursing education and then upon entering employment as an RN.
- Events that have been significant to the participant (disorienting dilemmas) resulting in their decision to remain working within the profession.
- Factors / strategies / supports (intrinsic and extrinsic) that have assisted participants to understand / cope with / learn from disorienting dilemmas.

Findings from this study will add to the development of nursing as a profession in the following ways:

- Improved patient care through the retention of experienced RNs.
- Enhanced educational experiences for student RNs and early career registered nurses.
- Increased knowledge for employers thus enhancing their ability to support more fully and effectively employees who are RNs as well as reduce economic burden of refilling positions.
- Adding to the mapping of the nursing profession and its history as a result of the collection of nurses' stories.

To be involved in this study participants will be asked to:

1. Read the information about the study and sign a consent form;
2. Complete a postcard, summarizing a significant event that you have experienced in the clinical setting and;
3. Participate in a face-to-face interview with the researcher to talk about that significant event. This may be in person, using Skype or similar.

Information packs will be sent out to RNs who express an interest in participating in the study – this will include:

- A blank postcard and stamped addressed envelope;
- An information sheet;
- Contact details and;
- Consent form.

Jane Douglas will conduct all interviews and will organize a time and venue that is convenient to the participant. **Please note, everything said will be treated with the utmost respect and confidentiality. All findings will be de-identified prior to dissemination so that individuals cannot be identified in any way.** In agreeing to take part, participants are also free to change their mind and withdraw from participating at any time.

Interviews will take the form of a discussion seeking to cover the issues mentioned above and lasting about 1 -1.5 hours. The interview will be recorded, transcribed, and analysed by the Principal Researcher, Jane Douglas, PhD Candidate, School of Nursing and Midwifery, University of Wollongong. A copy of the transcript will be given to participants to check before analysis.

If you would like to volunteer to participate in this research or would like more information, please contact:

Jane Douglas: jad679@uowmail.edu.au or phone 0418662913.

Appendix 2: Ethics approval letter



APPROVAL after review

In reply please quote: HE14/060

Further Enquiries Phone: 4221 3386

14 March 2014

Ms Jane Douglas
PO Box 3417
MANUKA ACT 2603

Dear Ms Douglas

Thank you for your letter responding to the HREC review letter. I am pleased to advise that the Human Research Ethics application referred to below has been **approved**.

Ethics Number: HE14/060

Project Title: Early Career Registered Nurses: How and why do they stay?
Exploring their disorienting dilemmas

Name of Researchers: Ms Jane Douglas, A/Professor Sharon Bourgeois, Mr Roy Brown,
A/Professor Catherine Hungerford

Documents Approved:

- Revised NEAF (dated 8/3/14)
- Appendix 1 - Postcard
- Appendix 2 - Participant Information Sheet
- Appendix 3 - Consent Form
- Appendix 4 - Invitation to participate
- Appendix 5 - Interview Schedule Guideline
- Approval Letter from University of Canberra

Approval Date: 13 March 2014

Expiry Date: 12 March 2015

The University of Wollongong/ISLHD Health and Medical HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research. The HREC has reviewed the research proposal for compliance with the National Statement and approval of this project is conditional upon your continuing compliance with this document.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at <http://www.uow.edu.au/research/rso/ethics/UOW009385.html>. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

Appendix 3: Participant information sheet

Participant Information Sheet for early career registered nurses.

Early Career Registered Nurses: How and why do they stay?

Researcher

Ms Jane Douglas

PhD Candidate, School of Nursing and Midwifery,

University of Wollongong, NSW, 2522

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Project Aim

The aim of this research is to investigate events that are significant (disorienting dilemmas) to early career registered nurses (RNs) currently working as RNs in Australia. These significant events (disorienting dilemmas) are experiences that are significant to the participant, causing them to question the way they think about being or working as a nurse. The study seeks to explore the impact that these events have upon this group and their decision to remain within the profession of nursing.

Benefits of the Project

The information gained from the research will inform employers, nurse educators, nursing students, health workforce planners and the wider community about the issues facing early career registered nurses in the workplace. It is anticipated that the results will be used to assist in the development of strategies that help to encourage nurses to remain within the workforce. The retention of experienced nurses in the workforce reduces economic strains upon the health system and leads to improved patient care (Allen, Fiorini, & Dickey, 2010).

General Outline of the Project

The nursing workforce in Australia and around the world faces severe shortage in the coming decades. Several reasons are suggested for the predicted shortage, including a changing demographic in communities and in the workforce itself. It has also been suggested that there are obstacles to retaining experienced staff, but this has been difficult to demonstrate. Whilst there has been much research to investigate the experiences of RNs in their first year of work as an RN, there has been little investigation into the experiences of nurses who have been working as RNs for one to five years. This study

investigates and analyses disorienting dilemmas identified by this group of RNs and what it is about those events that result in their decision to remain within the profession of nursing.

Participant Involvement

RNs who agree to participate in the research will be asked to sign a consent before undertaking the following:

Complete a postcard. On the postcard, participants will be asked to summarise an event that is significant to them (a disorienting dilemma) and has had an effect upon their nursing career. The Situation, Action, Outcome (S.A.O) approach will be used and asks the

- 1) participant to describe the event in relation to the Situation (what happened); their Actions or reactions (what did the participant do in response to this event) and the Outcome (what effect did this event have upon the participant in relation to their nursing career). A stamped addressed envelope will be provided so that participants can post this card back to the researcher. This will be used as a point of shared knowledge and a way of commencing and guiding the face-to-face interview.
- 2) **Participate in an interview** with the researcher at a convenient time and place. The interview will be face to face and may occur in person or through Skype (or similar). Interviews will not be undertaken during the participants' work hours or at their workplace. The interview will take about one to one and half hours and be audio-taped with the participants permission. Participants are asked to reflect upon events that have been significant to them creating a sense of disorientation and the effect these have had upon their nursing careers. This reflection will include consideration of their postcard description. A transcript of the recorded interview will be given to the participant for checking.

Participation in the research is completely voluntary and participants may, without any penalty, decline to take part or withdraw at any time without providing an explanation, or refuse to answer a question. Participants may choose to participate in one or both research components. The decision to participate or not will not be disclosed to participants employer/s.

The only potential risks to participation relate to privacy and confidentiality. All data collected from participants will be stored securely and only accessed by the researcher. Great care will be taken to ensure that any reports of the data do not name any individual or their circumstances.

Confidentiality

Only the researcher will have access to the individual, identified information provided by participants. Privacy and confidentiality will be assured at all times. The research outcomes will be provided in a thesis fulfilling the requirement for a degree at The University of Wollongong and may be presented at conferences and written up for publication. However, in all these reports, the privacy and confidentiality of individuals will be protected.

Anonymity

Due to the need to collect personal information from clients, it is not possible for the research to be anonymous. However, reports of the research will not contain information that can identify any individual and all information will be kept in the strictest confidence.

Data Storage

The information collected will be stored securely on a password protected computer throughout the project and then stored at the University of Wollongong for the required five year period after which it will be destroyed according to university protocols.

Ethics Review and complaints

The Human Research Ethics Committee of the University of Wollongong has reviewed this study. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the University of Wollongong Ethics officer on (02) 4221 3386 or email rso-ehitics@uow.edu.au
Ethics approval number: HE14/060

Queries and Concerns

Questions regarding the research, including cultural concerns can be directed to the researcher, Jane Douglas, whose contact details are at the top of this form and below. She welcomes answering any queries. Jane's PhD Supervisors from the University of Wollongong are also happy to answer questions regarding the supervision of this work.

Contact Details

Student:

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Reference

Allen, S., Fiorini, P., & Dickey, M. (2010). A Streamlined Clinical Advancement Program Improves RN Participation and Retention. *The Journal Of Nursing Administration*, 40(7/8), 316 - 322.

Early Career Registered Nurses:

How and why do they stay?

Information for participants

Dear

Thank you for your interest in the above study. Please find included in this pack,

1. An information Sheet
2. A consent form (for you to complete)
3. A postcard (for you to describe an experience that has been significant to you in your work as a nurse) and
4. A stamped addressed envelope.

If, after reading the enclosed information you are happy to participate in the study, I would ask that you complete,

- The consent form and
- The postcard

Could you return them via post in the stamped addressed envelope provided or bring them with you to the interview.

I will contact you via email or phone (depending upon the details I have) to negotiate a time and place to conduct the interview. I have an office in University Ave, Canberra where the interview could take place (and I will be happy to contribute towards parking costs) but there may be another venue that is easier for you. Please let me know if you have a preference for where you would like the interview to occur.

If you have any questions or need me to clarify anything, please don't hesitate to contact me. Thank you again for your interest in the study and I look forward to meeting you.

Kind regards

Jane

Jane Douglas
PhD Candidate
University of Wollongong
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Appendix 4: Consent form

Consent Form

Early Career Registered Nurses: How and why do they stay?

Early Career Registered Nurses: How and why do they stay?

Researcher: Jane Douglas. PhD Candidate University of Wollongong.

Email jad679@uowmail.edu.au or phone 0418662913

Student Supervisor: Dr Sharon Bourgeois, Associate Professor, School of Nursing and Midwifery, University of Wollongong sharon_bourgeois@uow.edu.au (02) 42215094

Consent Statement

I have read and understand the participant information about the research. I am not aware of any condition that would prevent my participation, and I agree to participate in this project. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

I understand that I can withdraw from the study at any time without affecting my relationship with the researcher now or in the future.

I understand that my involvement is confidential and that although the information given for the study may be published no information about me will be used in any way that reveals my identity

Please indicate whether you agree to participate in each of the following parts of the research (please indicate which parts you agree to by putting a cross in the relevant box):

- ☐ Complete a postcard summarizing a significant event that has had a direct effect upon my nursing career.
- ☐ Participate in a recorded (audio) interview with the researcher.

Name.....

Signature.....

Date

A summary of the research findings can be forwarded to you when complete. If you would like to receive a copy, please include your mailing (or email) address below.

Name.....

Address.....

.....

Appendix 5: The Participants

The following appendix provides an overview of the 13 ECRNs who participated in the study, including their age, years working as an RN, the places they had worked and where they were working at the time of the interview. Information has been deidentified and pseudonyms used.

Annabel

Annabel was 45 years old and had been registered as a registered nurse (RN) for five years following the completion of a Bachelor of Nursing (BN). Before this, she had trained and worked in Australia for 10 years as an enrolled nurse (EN). When I spoke with Annabel, she was completing a postgraduate, research degree in nursing. Annabel had finished her schooling overseas and moved to Australia as a young adult.

Following registration as an RN, Annabel completed a new graduate program in a perioperative speciality, which she said *wasn't awesome*. She said the reasons for this were *partly her fault, partly the program's fault and partly life*. At the end of the new graduate program, Annabel admitted that she felt *quite demoralised* and decided to take up a position at the hospital ward where she had worked previously as an EN. She had also started working as a casual academic at the local University and was enjoying teaching undergraduate students. Annabel had reduced her hours at the hospital to allow her to increase the number of hours she could devote to teaching.

Initially, Annabel said she could not isolate a specific reason for wanting to become a nurse but said it was something she had wanted to do from an early age.

In terms of choosing to study to become an RN rather than continue in her role as EN, she said of patient care,

I wanted to know what was happening, I wanted to know why it was happening, and I wanted to be able to do something about it, on the broader picture.

Annabel believed being an RN would enable that, and by that stage in her career, she felt ready to accept the responsibility associated with the RN role.

Cathy

Cathy was 27 years old, had completed a BN and been registered and working as an RN for 15 months. Prior to nursing, Cathy had worked in a variety of roles including disability worker, and personal carer in the aged care sector. Cathy said studying and caring for a family was challenging but also motivating.

Upon registering as an RN, Cathy completed a new graduate program in a medical nursing speciality with people who had chronic health conditions. The new graduate program involved rotations through the acute, outpatient and community settings. She said this provided her with a big picture view of the nursing speciality and helped her to understand the patient's journey.

Cathy continued to work in the hospital setting and in the same speciality, although said she would like to return to the community setting in the future. She had recently been awarded a scholarship to complete a post-graduate program in nursing.

As a child, Cathy recalled visits to the hospital with her sister. During these visits she said she observed what nurses did and the effect they had on people's lives, recounting,

...I just admired what nurses do and ... the role that they can play in other people's lives without really knowing them ... and how much trust you put into nurses. I just think ... you can make it better, being that person...

Chris

Chris was 44 years old when we spoke and in her fifth year working as an RN. She had completed a BN over three years. Chris had previously worked as a practice manager and a practitioner in alternative therapies. She lived with her family.

After completing a twelve-month, new graduate program in a tertiary care hospital, Chris moved to a position in the Intensive Care Unit (ICU) where she completed a transition to ICU program offered by the facility. Chris chose to continue working in the ICU part-time as it provided the flexibility to be involved in nursing related, extracurricular activities and the time to meet family and other life commitments.

Chris had taken up professional development opportunities offered through her employer including leadership and preceptor courses and was now accepting some leadership responsibilities.

Chris spoke of wanting to be a nurse since she was seven years old but *never got 'round to it* because *life took over*. She did say, however, that she was glad she hadn't become a nurse upon leaving school, as she thought she would not have been very good at it.

Claudia

Claudia was 23 years old and in her second year of practice as an RN when I interviewed her. She was working full time in the hospital where she had completed a new graduate program which involved rotations through various ward areas including ICU, the mental health unit and the medical ward.

At the time of our interview, Claudia was working on the nurse bank in the hospital where she had completed the new graduate program. The nurse bank was run by the employing hospital and RNs were able to signal their work availability and were allocated to work in areas requiring staff. Claudia chose to work primarily in acute and palliative care areas although she sometimes accepted shifts in the emergency department.

In her final year of school and unable to decide on a career, Claudia undertook a work experience placement in a nursing home. She recalled the experience as a powerful one and a time when she started to think about nursing as a career option. She spoke of developing new perspectives on life because of that experience. She said that caring for and being in the moment with the residents in the facility, had *changed everything* for her. She spoke about her experience of assisting with the care of a resident who was dying, and said,

I remember holding his hand and doing all the care for him ... and it just ... brought me out of my little 17-year-old bubble ... [it] showed me another side of humanity that I'd never sort of thought about. And everything, everything changed after that. I don't think I was the same and I think it made me grow up pretty quickly in a lot of ways.

It was this experience that helped Claudia to decide on a career in nursing.

Han

Han was 39 years old and in her third year working as a registered nurse. Han was born overseas and had worked for 10 years in another profession in her home country before moving to Australia with her family to study public health and then complete a BN.

Once registered as an RN, Han commenced a new graduate program at a tertiary hospital but left the program early to have a baby. She made the decision not to return to the program, choosing instead to accept a place in a graduate mental health program. Once completed, Han continued to work in the area of mental health rehabilitation, becoming a Clinical Nurse Specialist / RN2. A position she had held for 12 months at the time of our interview.

Initially, Han was nervous about working in mental health as she said that attitudes toward mental health in her home country were poor and wondered if this was the case in Australia. Discussions with friends helped her to decide that this type nursing was a way forward and, thought that in the future, she might have the opportunity to take new knowledge back to her home country and advocate for changes in practices and attitudes toward those with mental health conditions.

Helena

Helena was 23 and in her second year working as a registered nurse. She had commenced a BN directly after leaving school and said she enjoyed attending university excelling in the study of the human sciences. She admits some workplace experiences were better than others but understood that not every day would be a good one. Helena believed her time at university was a time to learn about nursing but also a time to learn about herself through study, meeting new people, moving away from home and other life experiences.

Once an RN, Helena commenced a 12-month new graduate program at a tertiary hospital. The program involved rotations through the mental health unit, ICU and the palliative care hospice. At the time of the interview, Helena was working with a nursing agency that supplied RNs to hospitals in the area. Working in this way allowed Helena some control over when and where she worked, including the decision not to work at the hospital where she had completed her new graduate program for reasons that became evident during our discussion. Her work assignments varied between medical, surgical, acute, aged care, coronary care and emergency areas. Helena said she enjoyed the variety of the work and the opportunity to learn about nursing in different settings. Working in the field of mental health during her new graduate year had been a highlight for Helena which influenced her decision to accept a position with the community mental health team, and she was due to start in that role in the weeks following our interview.

Helena said that she always knew she would work in a health-related area as the subject had always fascinated her. She said she achieved good results in her final year at school, but not

good enough to be accepted into physiotherapy or medicine, which were other areas she had considered. She was offered a place at university to study nursing, and following discussions with family and friends decided nursing presented a good career option.

Jan

At 47 Jan was in her fifth year working as a registered nurse. Jan's previous career had involved owning and operating her own business, but an economic downturn resulted in Jan having to decide to either move her business to another city or change careers; after much consideration, she decided to study nursing and completed a BN.

Following her graduation and registration as an RN, Jan had continued to study and at the time of the interview was completing a Master of Nursing through a university in Australia.

After completing a 12 month new graduate program, Jan had commenced work in a rehabilitation unit which catered for those requiring palliative care, awaiting placement to aged care facilities and those needing rehabilitation due to chronic illness or following a stroke. This was where Jan was working at the time of the interview.

Jon

Jon was 52 and in his second year working as an RN. He commenced his nursing career following 25 years of working in a variety of health-related fields.

During his BN studies, Jon worked as an Assistant in Nursing (AIN) in the aged care sector, developing a keen interest in the care of older adults. This was the career path he chose to follow, with a focus on dementia and gerontology. Jon said this choice was about giving something back to the people who had made his life in Australia possible.

Jon completed a 12month new graduate program that involved rotations through a medical assessment unit; an acute aged care unit and; a slow streamed rehabilitation area, where patients were stabilised and awaiting placement to residential care facilities or before returning home. Since registering as an RN, Jon had completed further studies in dementia care and continued to practice in residential aged care.

Jon decided to pursue a career in nursing following the death of a sibling. He said he understood that a career in nursing did not offer the same pay or conditions that were available in other occupations, but decided he wanted to do something for others explaining, *it wasn't about the money it was about me getting that self-satisfaction. And nursing's brought that...* Jon said he enjoyed working with people, reflecting that nursing is *...fantastic and the scope and the opportunities are just phenomenal. You know it really is the breadth; you can do so many things.*

Liz

Liz was 23 and in her second year working as an RN. She had taken a year off from study after finishing school and worked with people in their homes as a carer. Liz completed a new graduate program over 12 months in a tertiary hospital. The program involved three rotations

with placements in the mental health unit, the palliative care hospice and the acute, adult medical ward. Following completion of the program, Liz accepted an RN position on the acute, adult medical ward in that hospital and was still working there at the time of our interview.

Liz said she had always wanted to be a nurse. Her mother was a nurse, and Liz recalled growing up and listening to her mother's stories about her work which she felt had given her an idea of what nurses do. It was this that first sparked Liz's interest in becoming a nurse.

Polly

Polly was 31 years old, lived with her family and had been registered and working as an RN for three and a half years. Polly had moved to Australia with her family as a teenager. Following high school, Polly completed an undergraduate degree in a non-health related discipline before completing a BN.

Once registered as an RN, Polly completed a new graduate programme, describing this as one of the most challenging years of her life. Following the new graduate program, she completed a transition to ICU nursing program, offered to second year RNs interested in pursuing a career in ICU. Polly said she enjoyed working in the Intensive Care Unit but after a few months, decided to specialise further, moving to paediatric intensive care. Polly found the environment challenging and within three months of commencing had decided the work was not for her and moved to a position as a community nurse, which is where she was working at the time of our interview.

Polly said she had always wanted to be a nurse but had lacked the confidence and maturity to do it earlier and her mother had actively discouraged her from choosing nursing as a career. She said, however, the thought of becoming a nurse didn't go away. When asked why she wanted to be a nurse she said,

I guess I had expectations that I'd be able to do some good in the world ... That I'd have a job that was transferable because my husband was moving a lot. I didn't want to change the world. I don't think I had these great plans to go out and make massive differences. I thought it was ... a job that I can do, I can help people ...

Samuel

When I spoke with Samuel, he was 35 and in his second year of practice as an RN. Samuel had completed a BN in Australia. He said that there had been times during the degree where he doubted his decision to become a nurse and left before finishing the BN, deciding later to return and complete his studies.

Samuel completed a 12-month new graduate program, choosing a mental health speciality. The program involved three rotations through different mental health areas. At the time of the interview, Samuel was undertaking postgraduate studies. Since registering as an RN, Samuel had worked mostly in the mental health sector, including acute adult mental health units and community rehabilitation centres which he said provided him with a variety of experiences. He said he tended to be psychosocially focused and it was this that attracted him to that area of nursing. By the end of the new graduate year, due mainly to staff shortages, he was allocated to the team leader role on some shifts which he said was *fascinating and empowering*.

Samuel said his decision to enter nursing was related to his values especially having been the recipient of care in the past and seeing male nurses at work. Before commencing his nursing studies, Samuel worked as a carer for people with a disability. He said he felt that nursing seemed like a logical progression, stating,

I wanted to ... change the world. Cause I ... had some experiences ... as a disability carer ... which I didn't feel good about and wanted to see changed. And... I thought that maybe as a nurse you have a bit more... you have a lot more training, and you have a lot more credibility and would be regarded as a health professional.

Sarah

Sarah was 27 and in her second year of practice as an RN having completed a BN. She had moved interstate to undertake a new graduate program at a large, tertiary referral centre. Before commencing nursing studies, Sarah had completed a double degree in the humanities and was working in a related area.

Sarah's new graduate program involved rotations through several clinical areas across facilities including a major trauma centre. After the new graduate program, Sarah accepted a place in a transition to emergency nursing program in the same location. The program involved rotations through eight areas of emergency nursing.

Sarah said it took her a while to reach the decision to become a nurse. But her prior career path was not fulfilling. She said,

... I remember feeling that I wasn't satisfied coming home at the end of the day, I didn't feel like I was fully contributing anything to society. Even though, sure, some of the roles that I did were... they were valued... I wasn't robbing banks, but I just didn't feel like I had contributed anything to someone's life.

Sarah said she wanted to work in health because people needed to live and achieve certain things and to do that, they needed to be healthy. If she could assist people to be healthy, she could contribute to their lives and ultimately to society in a positive way. While looking at her options, she identified nursing as a possibility, eventually deciding on that pathway.

Susan

Susan was 25 and had been working as an RN for 16 months. She had volunteered for the study because of the five close friends she made during her time at university, she was the only one committed to remaining in the profession.

Susan completed a BN and was working as a community nurse and had enrolled in post-graduate studies, believing this offered a way to extend her knowledge and add value to the team with whom she worked. Susan said she would like to continue her education ... *perhaps in primary health care or even complex care ... because she said, I think ... that sort of role's really going to be quite valuable in a few years.*

Following completion of her school education, Susan had studied teaching at university but left after one year. She said that in hindsight, she was probably too young to start university and did not really know what she wanted to do. Susan commenced in a full-time position as a

receptionist in a medical practice, and it was here that she met, observed and learned about the work of practice nurses, deciding that nursing as a career looked and sounded interesting.